



Workforce Solutions 2026 Emergency Medical Services Study

Submitted By

MCM Consulting Group, Inc.

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Executive Summary

This Emergency Medical Services (EMS) study, conducted by MCM Consulting Group, Inc. on behalf of Workforce Solutions for North Central Pennsylvania, provides a comprehensive assessment of EMS delivery across Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties. The study evaluates workforce conditions, system performance, financial sustainability, training pathways, and operational challenges, while identifying actionable strategies to strengthen and modernize EMS systems in a predominantly rural region. The findings reveal a system that continues to function due to the dedication and adaptability of its providers but is increasingly under strain from demographic, financial, and structural pressures that threaten long-term sustainability.

The study region is characterized by low population density, significant geographic dispersion, and an aging population that exceeds state and national averages. These demographic conditions directly drive EMS demand, as older populations utilize emergency services at higher rates due to chronic illness, mobility limitations, and complex medical needs. At the same time, population decline and workforce contraction reduce the available pool of EMS providers and the tax base needed to support services. These combined factors result in higher per-capita demand for EMS, longer response, and transport distances, and increased operational costs, creating a difficult environment for service delivery.

One of the most significant findings of the study is the ongoing workforce crisis affecting EMS agencies throughout the region. Recruitment and retention challenges are widespread and driven by multiple factors, including declining volunteerism, increasing training requirements, evolving testing requirements, limited compensation, demanding schedules, and fewer long-term career pathways. Many agencies rely on a hybrid staffing model that includes a mix of paid, part-time, and volunteer personnel, yet even with these approaches, staffing shortages persist. Agencies report small operational workforces, often averaging approximately less than fifteen active personnel, and frequently depend on mutual aid to meet coverage demands. The reliance on shared staffing pools increases the risk of fatigue and burnout, particularly as individuals often serve multiple agencies or roles.

Training and certification barriers further constrain workforce development. Prospective EMS providers frequently encounter challenges related to cost, accessibility, and the rigor of certification requirements. Provider reported limited access to training programs in rural areas, combined with travel distances and financial burden, reduces participation and completion rates. Without intervention, these barriers will continue to limit the pipeline of new EMTs and paramedics entering the workforce. The study highlights the need for coordinated regional



training efforts, partnerships with educational institutions, and expanded financial support mechanisms such as scholarships, tuition assistance, and apprenticeship models.

Financial instability is another defining challenge across the EMS system. Most agencies operate with budgets ranging from modest to multi-million-dollar levels; however, the majority report operating deficits. Billing from calls for service remains the primary revenue source, with additional support from grants, fundraising, municipal contributions, and donations. Despite these efforts, revenue is insufficient to sustain operations, particularly due to reliance on Medicare and Medicaid reimbursement rates and inconsistent collection performance. Many agencies lack formal business management expertise, which further limits their ability to optimize financial performance, control costs, and plan for long-term sustainability. The study emphasizes the importance of approaching EMS from a business perspective, incorporating financial planning, billing optimization, shared services, and diversified funding strategies.

Operationally, EMS agencies face significant challenges related to coverage, deployment, and resource availability. Agencies frequently experience gaps in coverage due to staffing shortages, unpredictable scheduling, and extended call durations. Transport times are often extended, frequently exceeding 30 to 60 minutes and are compounded by hospital turnaround delays, which further extend unit out-of-service time. Survey data shows that agencies are out of service an average of approximately 14% of the time, with some reporting significantly higher rates. The system relies heavily on mutual aid not as a backup, but as a routine component of service delivery, reflecting a system operating near capacity.

Much like the closure of the Penn Highlands Elk labor and delivery unit, the closure of Bradford Regional Medical Center is a significant turning point for the region's EMS and healthcare systems. The loss of these units and facilities has increased transport times substantially. Longer transports reduce ambulance availability, increase operational costs, and elevate clinical risk for time-sensitive emergencies.

The study also identifies inefficiencies in the interface between EMS and hospital systems. Similarly, gaps in communication between EMS agencies and dispatch centers reduce situational awareness and can delay response to new calls. Standardization of communication protocols, improved coordination with Public Safety Answering Points (PSAPs), and enhanced real-time tracking of unit availability are recommended to improve system performance.

Despite these challenges, the study identifies several opportunities for improvement and transformation. Regional collaboration, shared staffing models, coordinated deployment strategies, collaborative billing, and consolidated administrative functions are all tenants outlined within the following pages.



Innovative approaches and alternative response models have the potential to reduce system demand. These strategies, when combined with public education and improved awareness of appropriate 911 utilization, can help balance demand and improve system efficiency. At the same time, workforce-focused strategies including flexible scheduling, mentorship programs, and public recognition campaigns can support recruitment and retention efforts.

Existing regional workforce development resources can support these efforts by connecting EMS agencies with recruitment, training, career awareness, and work-based learning strategies. Opportunities include Incumbent Worker Training to support the upskilling and retention of existing employees; Registered Apprenticeship pathways that combine paid employment, structured on-the-job learning, related technical instruction, mentoring, and progressive skill development; and PA Six Careers to increase awareness of EMS occupations and connect students, PA seekers, and career changers with regional career opportunities.

Sustainable funding remains a critical priority, and the study identifies several opportunities to strengthen financial stability.

Ultimately, long-term sustainability will depend on a coordinated, multi-faceted approach that integrates workforce development, financial reform, operational improvements, and regional collaboration. The EMS system in north central Pennsylvania is at a critical juncture while the challenges are significant, the opportunities for transformation are equally substantial. By leveraging data-driven decision-making, fostering partnerships across agencies and sectors, and investing in both people and systems, the region can transition from a fragile system reliant on individual effort to a resilient, sustainable model of rural emergency medical care.

The findings and recommendations outlined in this report provide a roadmap for that transformation, emphasizing that coordinated action today is essential to ensure reliable, high-quality EMS for the communities served both now and in the future.



Project Team

The project team consisted of:

Hon. Martin Causer, Pennsylvania State Representative
Rhonda Race, District Director
Hon. Carol Duffy, McKean County Commissioner
Hon. Tom Kreiner, McKean County Commissioner
Hon. James Moate, Cameron County Commissioner
Hon. Greg Gebauer, Elk County Commissioner
Hon. Mark Humes, Jefferson County Commissioner
Hon. Robert Rossman, Potter County Commissioner
Pam Streich, Workforce Solutions
Donna Hottel, Workforce Solutions
Laura Narby, Cameron County
Blaine Manginell, Cameron County
Dave McClure, Clearfield County
Mike McAlliser, Elk County
Jim Lipuma, Jefferson County
Tracy Zents, Jefferson County
Chris Clark, Jefferson County
Nathan Burgett, McKean County
Stephanie Scrivo, McKean County
Gerard Rettger, McKean County
Glenn Dunn, Potter County
Kathy Brooks, Potter County
Sally Scrivo, Bradford Area Transport Service
Brett Butler, Bradford City Fire
Jeff Reeser, EMS West
Michael Valine, UPMC
Lisa Rice, Tioga County 911 Director
Jim Douglass, Deputy Director of 911
Michael McGrady, Principal/Chairman, MCM Consulting Group, Inc.
Kristy Agosti, President/CEO, MCM Consulting Group, Inc.
Michael Rearick, Director of Operations, MCM Consulting Group, Inc.
Jeffery P. Steiert, Project Manager, MCM Consulting Group, Inc.
Daniel Becker, Consultant, MCM Consulting Group, Inc.
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Adam Leister, Senior Consultant, MCM Consulting Group, Inc.
Valerie Zents, Senior Consultant, MCM Consulting Group, Inc.



Project Scope

MCM Consulting Group, Inc. assisted the North Central Workforce Development Board (dba Workforce Solutions for North Central PA) with emergency medical services (EMS) consulting, planning, and EMS subject matter expertise to assess the EMS systems of each local emergency medical service in the region (Cameron County, Clearfield County, Elk County, Jefferson County, McKean County, and Potter County), and provided recommendation of models that support paid staffing, while preserving volunteer engagement, leadership development and succession planning. The following is an outline of the scope of work required to complete this project:

Project management

- MCM conducted a project kickoff meeting with the North Central Workforce Development Board and the necessary stakeholders to review the project and develop an approach for successful completion.
- MCM conducted one in-person meeting per month and one virtual meeting per month to keep all stakeholders apprised of progress and identify any obstacles encountered in addition to corrective actions to be taken to prevent delays. Following the project kickoff meeting, the project team agreed to meet on the second and fourth Tuesday each month at 2:30 p.m. The project team recommended converting the in-person meetings to all virtual meetings, which was agreed upon during one of the project meetings.
- Developed a project schedule. All meetings were preceded by an agenda and followed by meeting minutes.
- Typical involvement of the project team members included attending project meetings in person or virtually, providing requested information and local expertise and periodically working in small groups with the MCM team for specific time sensitive tasks.
- MCM utilized project management software to ensure all project tasks were completed on schedule.

Data collection and stakeholder engagement

The following outlines MCM's approach to this section.

- MCM reviewed the current plans, reports, data, and other statistics provided by the counties dispatch centers within the region.
- MCM identified EMS and QRS agency information and the current status of EMS in the region.
- MCM created heat maps and data tables to reflect EMS and QRS call volumes.



- Developed maps using GIS data to reflect call volumes for previous years and call volume at various times of the day.
- Developed maps using GIS data to reflect 2023-2025 call volume.
- Illustrated the scratch rate (“did not crew”) of EMS and QRS calls for a time frame that was identified by the project planning team as 2023, 2024, and 2025.
- MCM reviewed all current response box assignments and current mutual aid companies.
- MCM developed an interview packet that was utilized to review the status of EMS and QRS responses and operations in the region. The following outlines the interview process and documentation of the interview results.
 - Established an interview packet that was utilized for all stakeholders. An online survey was also utilized prior to the interviews to capture key data to discuss during the interviews.
 - Conducted interviews with the municipal elected officials, key EMS and QRS agencies, and other key agencies as identified in the kickoff meeting.
 - Compiled all interview responses and developed an interview summary report that was utilized and integrated into the overall EMS study.
 - MCM developed a data collection and stakeholder engagement summary (including engagement with EMS leadership).

Workforce Recruitment and Retention Analysis

The following outlines our approach to this section.

- MCM identified primary barriers to recruiting and retaining EMTs and paramedics in both career and volunteer agencies.
- MCM evaluated turnover trends and workforce demographics to forecast future staffing risks.
 - MCM developed strategies such as tuition assistance, stipends, housing/childcare support, and other incentive-based workforce models.
- MCM developed maps, charts, and visual summaries illustrating service coverage, workforce distribution, or response time trends.
- MCM evaluated regional adult EMS student (age 30+) training and certification pass rates compared to the national registry test pass rates, identifying disparities and barriers to success.
- MCM analyzed workforce composition to project the impact of declining volunteer participation on system readiness and community coverage.

Training and Certification Pathways



The following outlines our approach to this section:

- MCM assessed accessibility, affordability, and availability of EMT and paramedic training programs within and near the region.
 - This included primary training programs like EMR, EMT, AEMT and paramedic and included continuing education.
- MCM identified opportunities for partnerships with schools, postsecondary institutions, and Workforce Solutions to “grow our own” EMS professionals.
 - In person or virtual interviews were conducted to gather information from this academia.
- MCM recommended mentorship, apprenticeship, or accelerated pathways for training.
- MCM examined state versus national certification requirements and their workforce implications.
- MCM assessed how EMS instructors are maintaining compliance with annual training updates and curriculum changes and identified needs for ongoing instructor development.
- MCM recommended approaches for regional consistency in protocol updates, instructor training, and education delivery.

Staffing, Coverage, and Deployment Models

The following outlines our approach to this section:

- MCM evaluated how workforce shortages impact response times, coverage reliability, and after-hours capacity.
- MCM assessed municipal EMS governance structures, including funding mechanisms, volunteer support programs, mutual aid agreements, and designation of primary providers.
- MCM analyzed whether municipal/agency policies align with Pennsylvania EMS statutes and regulations and how these policies influence workforce sustainability.
- MCM explored regionalized staffing, shared personnel pools, and county-supported float positions.
 - MCM utilized modeling and mapping to illustrate how this could be accomplished.
- MCM recommended placement pathways for newly trained personnel while ensuring compliance with municipal/agency obligations and legal constraints.
- MCM compared current county EMS provider rosters to the number of individuals actively serving in field operations, to identify staffing gaps.



- MCM evaluated the impact of secondary or legacy ambulance licensing requirements and whether these contribute to inefficiencies or unfunded mandates.
- MCM examined response patterns today versus projected future needs, using data to show where system redesign or resource realignment may be needed.

Compensation, Funding, and Sustainability

- MCM compared compensation, benefits, and incentive structures across the region and neighboring counties.
 - MCM also utilized best practices from the previous EMS projects completed.
- MCM identified sustainable funding sources to support workforce investments (e.g., grants, partnerships, public-private models).
 - MCM leveraged the EMS councils for details as well.
- MCM analyzed municipal and county-level funding mechanisms, including millage, per capita, and fee-based models, to determine feasible options for sustainable EMS funding.
 - MCM also utilized best practices from the previous EMS projects completed.
- MCM explored potential for state-class county EMS allocations or shared funding formulas.
- MCM evaluated how changes from volunteer to combination or paid departments affect taxation, insurance, and workers' compensation liabilities.
- MCM assessed the feasibility of allowing stipends and performance-based funding under existing fire and EMS grant programs.
- MCM considered opportunities for cost recovery for lift assists, QRS calls, or other low-acuity services.
 - MCM also utilized best practices from the previous EMS projects completed by MCM.

Volunteer and Combination Agency Support Strategies

- MCM examined unique workforce pressures facing volunteer and combination departments.
 - Information was also gathered during the interview process.
- MCM recommended models that balance paid staffing with volunteer engagement and leadership development.
 - MCM also utilized best practices from the previous EMS projects completed by MCM.



- MCM assessed how volunteer agencies can remain operational under evolving workforce and funding models, and what legislative or regional support could aid in their transition to hybrid structures.
 - MCM also utilized best practices from the previous EMS projects completed by MCM.

Regional Collaboration Frameworks

- MCM recommended governance or coordination structures that preserve local agency identity and ensure compliance with Pennsylvania EMS law.
- MCM addressed questions such as:
 - How many ambulance services are needed in each county? (staffed ambulance units and location)
 - What balance of ALS (Advanced Life Support) vs. BLS (Basic Life Support) services is appropriate?
 - How do municipal/agency policies and funding impact workforce deployment and regional coordination?
- MCM developed recommendations regarding the following.
 - Provide recommendations on the number of stations and utilization of ALS, BLS and QRS apparatus
 - Based on the inventory of EMS response equipment and personnel, identify recommendations to utilize these assets to provide enhanced EMS in the geographic region
 - Develop recommendations to improve billing to increase revenue received in the EMS region
- MCM evaluated communication among EMS, 911 centers, and hospitals, identifying opportunities for a regional coordination model that aligns triage, dispatch, and resource allocation.
- MCM reviewed dispatch protocols for non-emergency call redirection or nurse triage systems, including cost savings projections per county or agency.
- MCM identified how mutual aid agreements are functioning and where failures to respond are creating systemic risk.

Public Awareness and Community Support

The following outlines our approach to this section.



- MCM assessed public perception of EMS careers and identified outreach methods to strengthen recruitment.
- MCM recommended communication and messaging strategies to raise awareness of EMS workforce challenges.
- MCM included public education considerations regarding system capacity, coverage limitations, and realistic expectations for EMS response times, particularly as volunteer participation declines.

System Flow, Dispatch Impact, and Hospital Interface

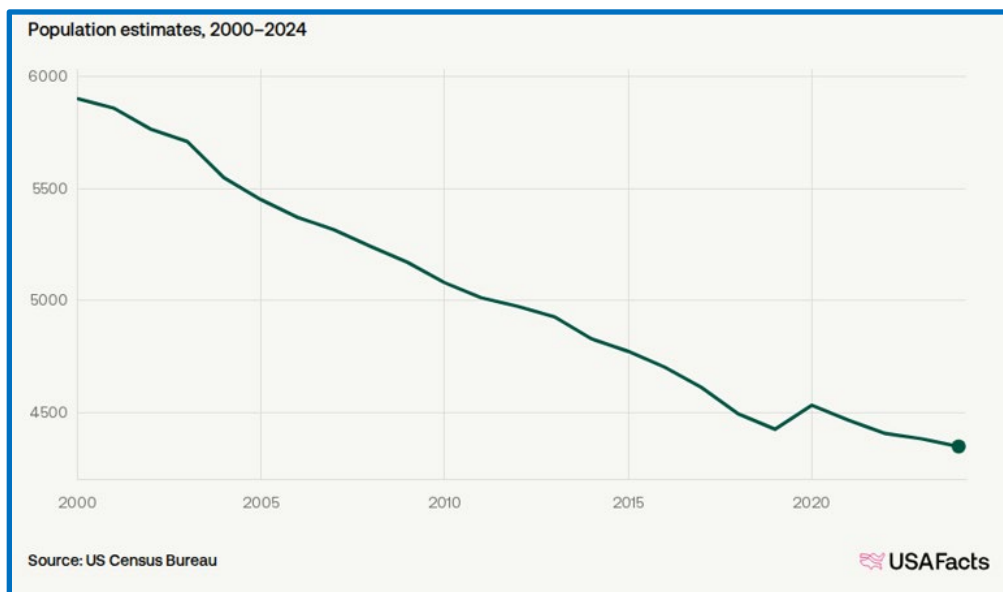
- MCM analyzed the impact of workforce shortages on 911 dispatch operations, hospital turnaround times, and mutual aid.
- MCM recommended coordination strategies between EMS, dispatch centers, and hospitals to improve efficiency and reduce staff burnout.
- MCM mapped and analyzed non-emergency call volumes to estimate the potential impact of nurse triage, telehealth, or deferred transport protocols.
- MCM identified hospital-related factors (closures, offload delays, long-distance transports) that contribute to extended EMS engagement times and workforce fatigue.
- Ambulance and station placement suggestions
 - Coordinated with the project planning team to evaluate and determine the locations for placement of EMS stations and apparatus in the selected region.
 - Utilized GIS data and maps to assist with this planning process and to reflect results.
 - Identified and developed maps to reflect response times to parts of the selected region based on unit placement.
- MCM provided general EMS guidance and subject matter expertise as it relates to EMS planning, training, and overall operations.



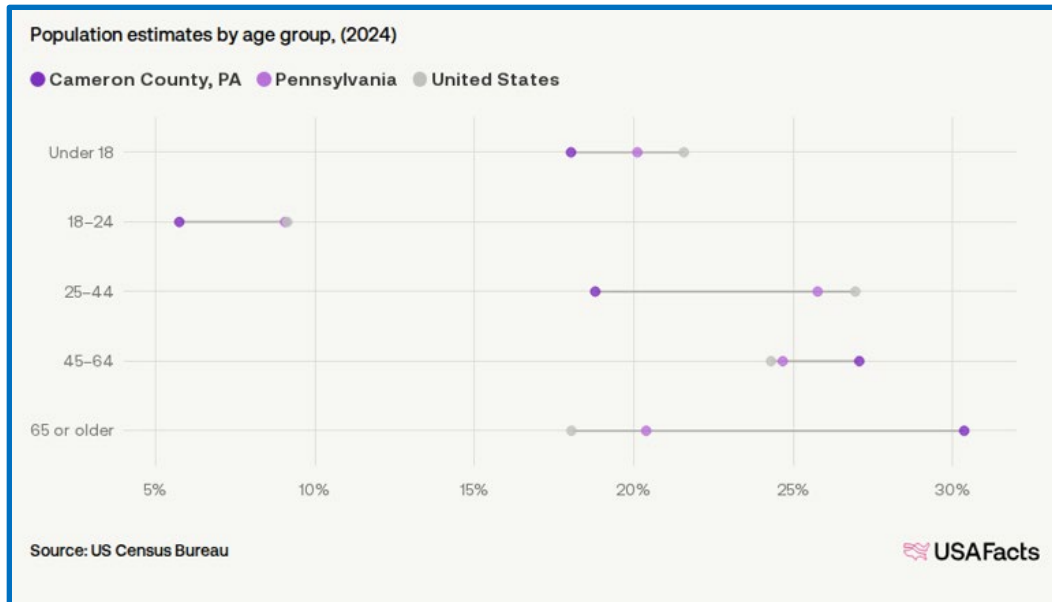
Background and Introduction

Cameron County

Cameron County is one of Pennsylvania's smallest and most sparsely populated counties, with an estimated 4,200 residents and an extremely low population density of approximately 11 people per square mile. The county is highly rural, has no interstate or U.S. highways, and has experienced population decline exceeding 7% since 2020.



Cameron County also has the oldest population profile in the region, with nearly 30% of residents aged 65 or older and a median age exceeding 51 years.

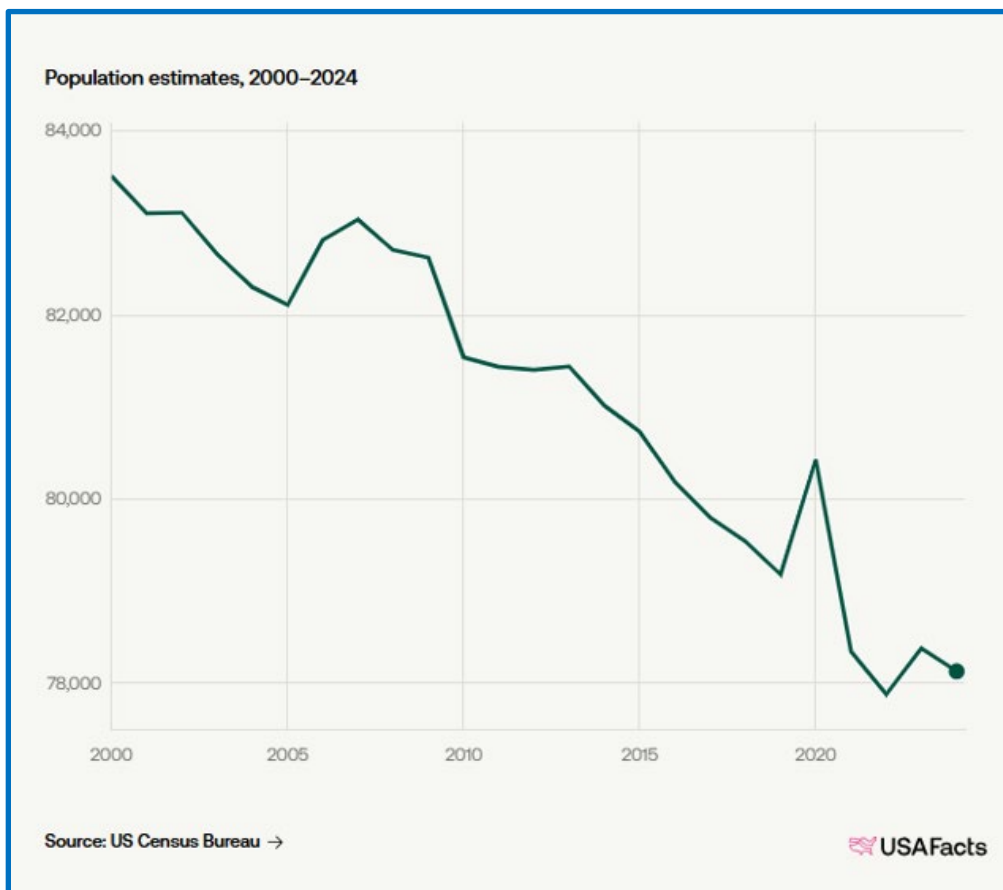


Housing vacancy rates are very high, reflecting both population loss and seasonal or unused housing stock. The combination of extreme rurality, declining population, transportation limitations, and advanced age demographics presents significant challenges for service delivery, emergency response times, and access to healthcare and social supports, challenges that are further exacerbated by the absence of any hospital within Cameron County, requiring all residents to seek emergency care outside the county.



Clearfield County

Clearfield County is the most populous county in the study area, with an estimated 78,000 residents and a population density of approximately 68 people per square mile. While larger than the surrounding counties, Clearfield remains predominantly rural, with over 60% of residents living outside urbanized areas.

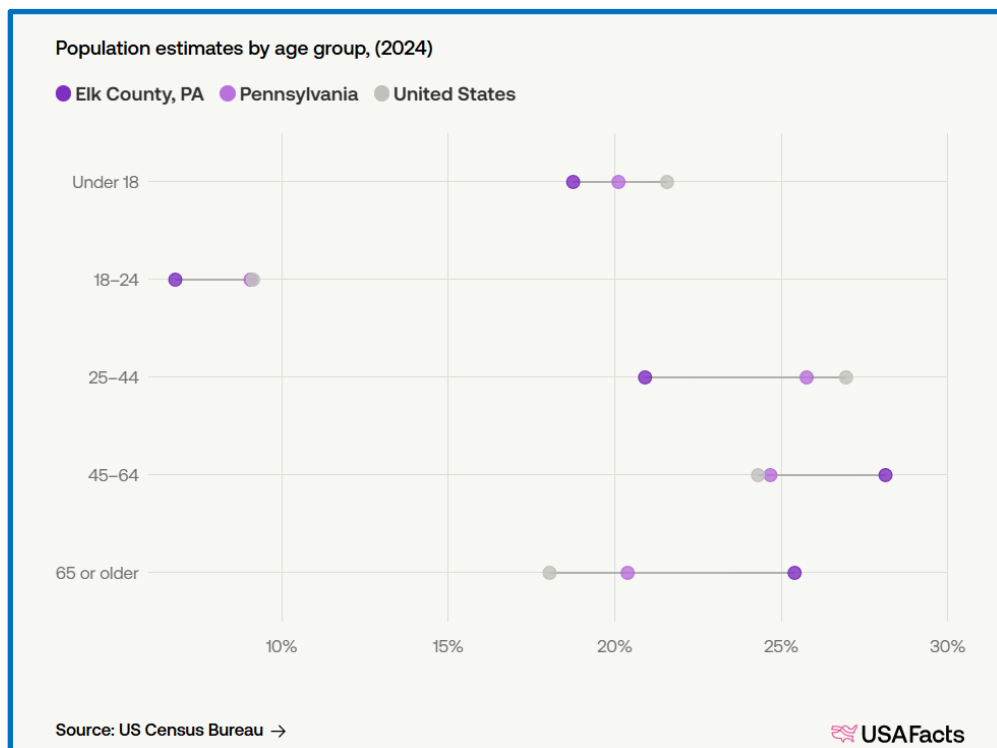


The county's median age is approximately 46 years, and more than one-fifth of the population is aged 65 or older. Population trends indicate gradual decline since 2000. Clearfield County has a sizable number of households made up of individuals, including older adults living alone, and a housing vacancy rate near 15%. As a large, mountainous county with dispersed communities, Clearfield plays a central role in the region while still facing rural access challenges related to transportation distances, service coverage, and the needs of an aging population.

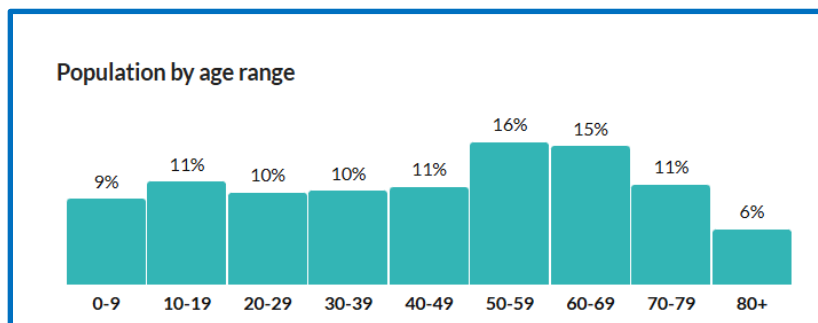


Elk County

Elk County is a sparsely populated, predominantly rural county with approximately 30,500 residents as of 2024–2025 and a low population density of about 37–38 persons per square mile. The county’s population has remained relatively stable over the past decade but is notably older than state and national averages.



Approximately 25% of residents are aged 65 or older, while fewer than 19% are under age 18. The median age is approximately 48 years.

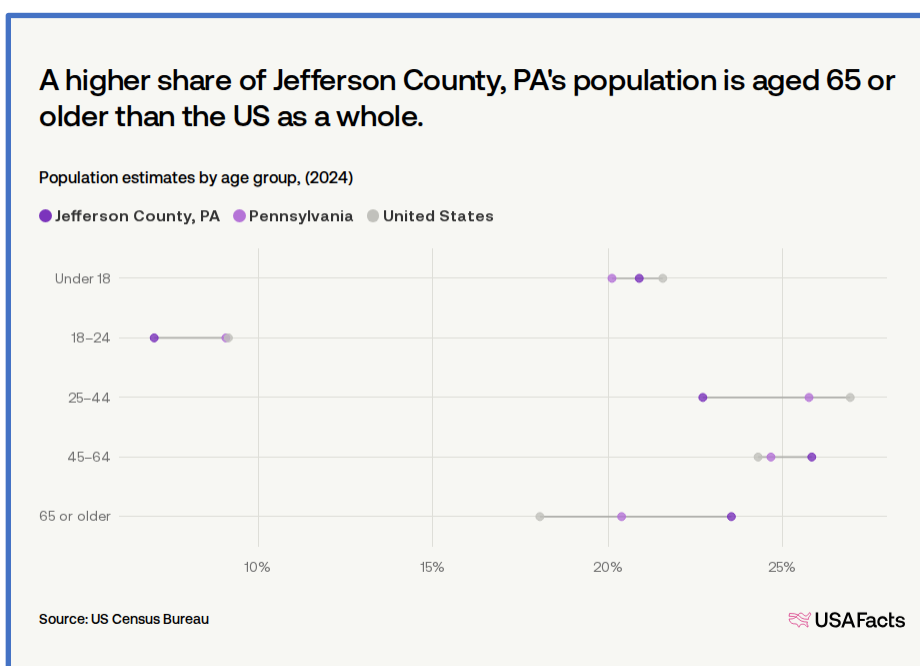




Population is concentrated in communities such as St. Marys, Johnsonburg, and Ridgway, while large portions of the county remain remote and rural. Housing vacancy rates and the proportion of residents living alone, particularly older adults, suggest potential challenges related to access to services, transportation, and healthcare delivery in outlying areas. Overall, Elk County exhibits the demographic characteristics of an aging rural population with moderate population decline and limited density that can strain service availability across a large geographic footprint.

Jefferson County

Jefferson County has an estimated population of approximately 43,000 residents and is overwhelmingly rural, with roughly three-quarters of residents living outside urban areas. The median age is about 45 years, and more than 22% of residents are aged 65 or older, exceeding state and national averages.

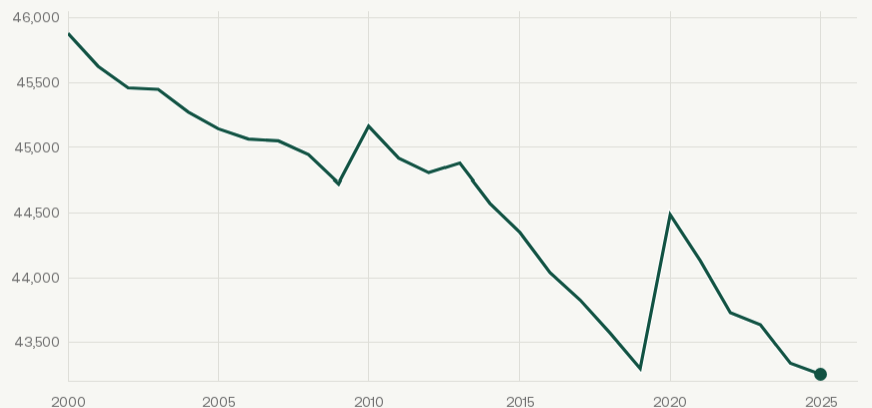


While the county remains demographically stable, population trends show a slow decline over time.



About 43,300 people lived in Jefferson County, PA in 2025.

Population estimates, 2000–2025



Source: US Census Bureau

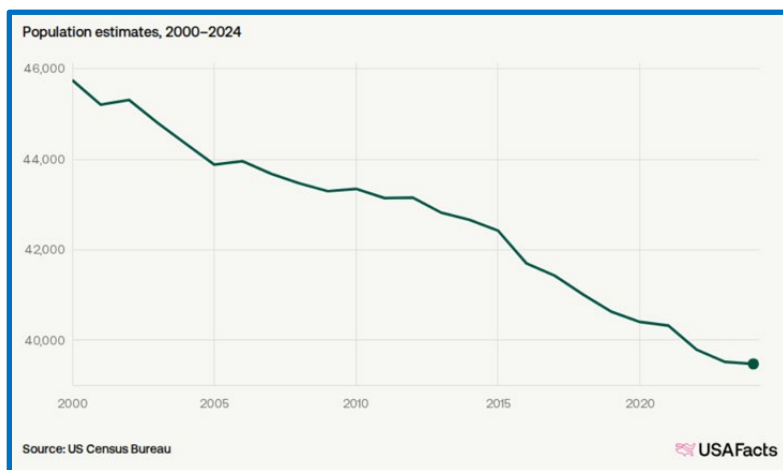
USAFacts

Household composition indicates a significant percentage of individuals living alone, including older adults, and relatively high housing vacancy rates. Jefferson County’s combination of rural settlement patterns, aging demographics, and declining population suggests growing pressure on healthcare, emergency response, and human service systems that must cover wide geographic areas with limited resources.

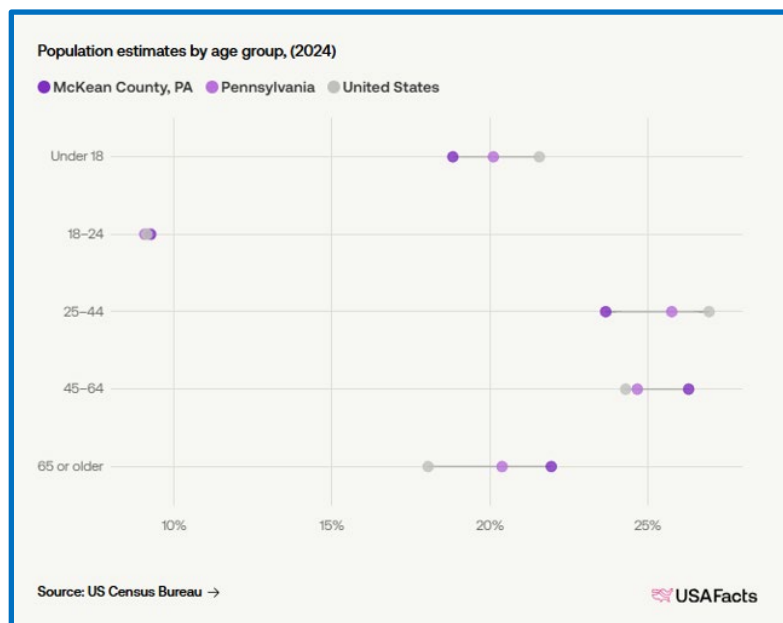


McKean County

McKean County has an estimated population of approximately 39,000 residents and a low population density of about 41 people per square mile. More than 70% of residents live in rural areas.



The county's median age is approximately 44 years, and over 20% of residents are aged 65 or older. Population decline has occurred steadily since 2000.



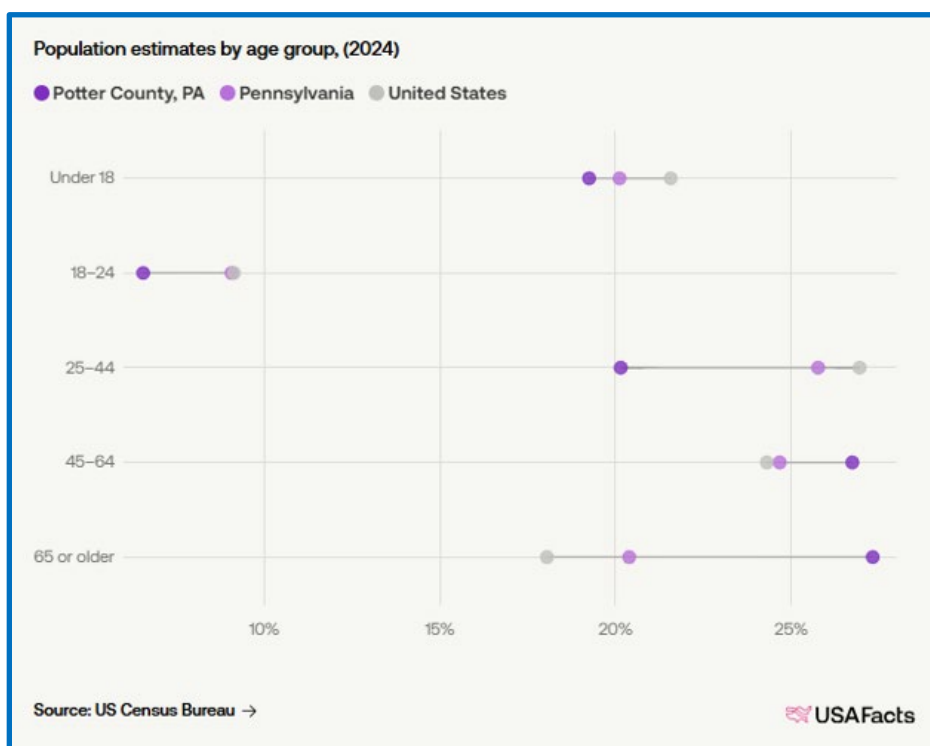
McKean County includes significant forested and recreational land, further dispersing communities, and limiting accessibility. Household data indicate a substantial number of



individuals living alone, including older adults. These characteristics underscore ongoing challenges related to workforce availability, healthcare access, and service coordination across a broad rural landscape. Further complicating access to healthcare, Bradford Regional Medical Center (BRMC) recently closed. This closure not only reduces access to healthcare in a populous area but significantly impacts transport times to other facilities and as a result reduces the number of availability of EMS. Information on impacts created by the closure of BRMC is expanded in a later section of this report.

Potter County

Potter County is a large, geographically remote county with a very low population density, approximately 15 people per square mile, and fewer than 16,000 residents. The county is widely recognized for its rural and isolated character. Population trends show gradual decline, and more than 27% of residents are aged 65 or older, among the highest proportions in the region. Although children make up roughly 19% of the population, overall demographics reflect an aging and shrinking population base.



The county's size, remoteness, aging population, and limited infrastructure contribute to substantial challenges related to access to healthcare, transportation, and emergency services.



Regional Summary and Key Findings

Collectively, the counties in the study region—Elk, Clearfield, Jefferson, Cameron, Potter, and McKean, form a predominantly rural, sparsely populated area of north-central Pennsylvania characterized by aging populations, population decline, and low population density. All counties exceed state and national averages for residents aged 65 and older, with Cameron and Potter Counties showing particularly pronounced age imbalances. At the same time, the proportion of children and working age adults is lower than statewide norms, indicating limited population replacement and a shrinking labor force.

Geographically, the region is expansive and mountainous, with many communities separated by long travel distances and limited transportation infrastructure. Housing vacancy rates are consistently high, especially in the most rural counties, reflecting population decline, seasonal housing, or economic stagnation. Across the region, a significant number of households consist of individuals living alone, including older adults, increasing vulnerability to health emergencies, social isolation, and access barriers.

Taken together, these factors suggest a region facing structural challenges in service delivery, particularly healthcare, emergency medical services, transportation, and human services. Low density and dispersed settlements increase response times and operational costs, while the aging population increases demand for medical and supportive services. The regional profile highlights the need for collaborative, flexible, and innovative approaches to sustaining essential services—particularly models that account for distance, limited workforce availability, and the growing healthcare needs of older adults.

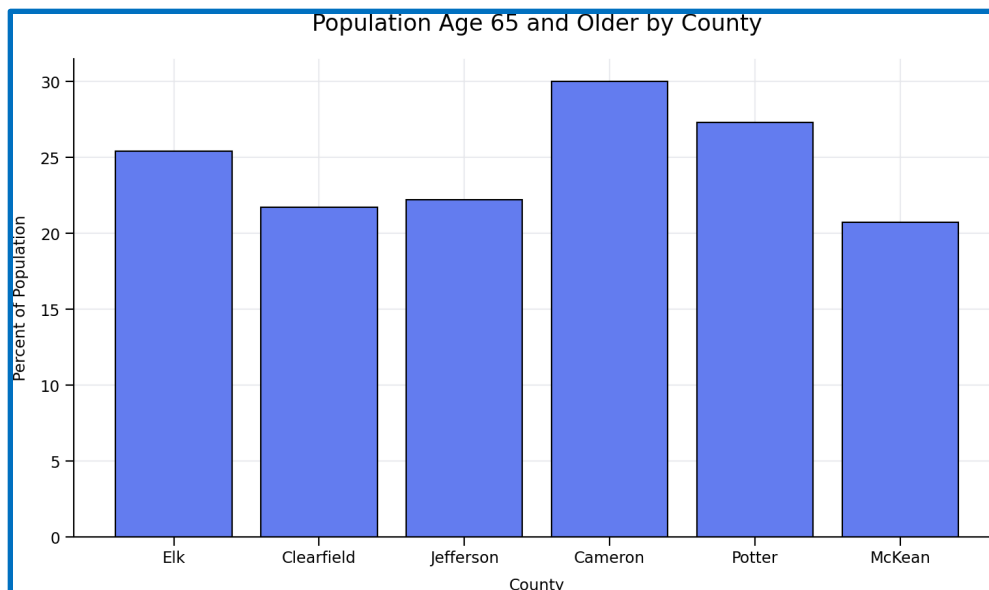
Population Age and Density are Key Drivers of EMS Demand

The study region is defined by two dominant demographic characteristics that strongly influence emergency medical services (EMS) demand:

1. An aging population, and
2. Very low population density across large geographic areas.

Across all six counties, Elk, Clearfield, Jefferson, Cameron, Potter, and McKean, the percentage of residents aged 65 and older exceeds state and national averages. At the same time, counties are geographically large and sparsely populated, requiring EMS systems to cover extensive service areas with relatively few residents and limited infrastructure.

The figure below illustrates the proportion of residents aged 65 and older by county, highlighting the advanced age profile of the region.



Cameron and Potter Counties stand out with nearly 30% of residents aged 65 or older, while Elk County exceeds 25%. Even the more populous counties, Clearfield, Jefferson, and McKean, have elderly populations exceeding 20%. These age profiles are particularly significant for EMS systems, as older adults utilize emergency medical services at substantially higher rates than younger populations due to chronic illness, mobility limitations, falls, cardiac conditions, respiratory illnesses, and medication-related emergencies.

County Level EMS Demand Implications

Elk County

Elk County's aging yet relatively stable population creates sustained and predictable demand for EMS services, particularly for age-related medical calls. With a quarter of the population over the age of 65 and a median age near 48, demand is likely driven less by trauma and more by medical emergencies, and frequent users requiring repeat EMS responses. The county's low population density and dispersed settlements increase response times and unit utilization, placing added strain on ambulance availability, especially during peak demand hours.

Clearfield County

As the most populous county in the region, Clearfield County serves as a regional hub while still being over 60% rural. Although its population density is higher than neighboring counties, large portions of the county are mountainous and difficult to access during inclement weather. The sizable population aged 65 and older contributes to a steady volume of EMS calls, while long



transport distances to hospitals increase unit hours per call. This dynamic often results in fewer available ambulances at any given time, increasing the likelihood of mutual aid reliance and delayed coverage for remote areas.

Jefferson County

Jefferson County's highly rural settlement pattern, combined with more than one-fifth of residents aged 65 and older, creates persistent EMS demand spread over a wide service area. A significant portion of households consist of individuals living alone, many of whom are older adults. This population characteristic is commonly associated with higher EMS utilization due to delayed care-seeking, falls, and lack of informal caregivers. As population decline continues, EMS systems may face rising per-capita demand even as total population decreases.

Cameron County

Cameron County presents the greatest EMS access challenge in the study area. It combines extremely low population density with the oldest median age in the region. Nearly one-third of residents are aged 65 or older, and the county's limited roadway network lacks interstate or U.S. highways. These factors contribute to longer response times, extended transport durations, and increased operational costs per call. Although call volume may be lower in absolute numbers, call complexity, response burden, and service intensity are disproportionately high, placing significant stress on limited EMS resources.

Potter County

Potter County's vast geography, very low population density, and aging population produce EMS demand patterns similar to Cameron County but at a larger geographic scale. Long travel distances, high housing vacancy rates, and seasonal population fluctuations further complicate service planning. With over 27% of residents aged 65 or older, EMS demand is increasingly driven by chronic medical conditions and repeat service use, while volunteer recruitment and workforce sustainability remain ongoing concerns in such a remote setting.

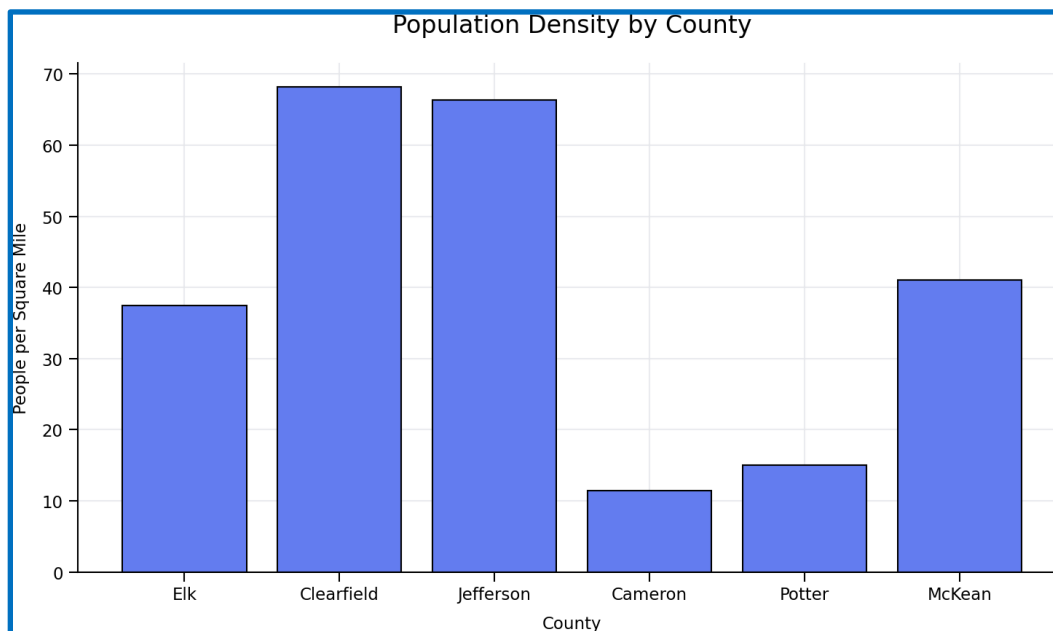
McKean County

McKean County's predominantly rural population and extensive forested land result in moderate population density but significant service dispersion. The aging population contributes to sustained EMS utilization, while declining population trends reduce the local tax base that supports emergency services. The combination of geographic dispersion and a growing elderly population increases the likelihood of single unit responses being unavailable for extended periods due to long call and transport times.



Population Density and Service Area Challenges

The figure below highlights population density across the study counties, underscoring the logistical challenges inherent in serving large rural areas with limited population concentrations.



Population densities range from approximately 11 people per square mile in Cameron County to fewer than 70 people per square mile in the most densely populated counties. Low density directly correlates with longer EMS response times, fewer available units, and higher costs per response. Unlike urban systems, rural EMS agencies must maintain readiness across expansive territories despite relatively low call volumes in some areas, compounding financial and staffing challenges.

Regional EMS Demand Outlook

Taken together, demographic trends in the region point toward increasing EMS demand per capita, even as the total population continues to decline. Aging populations, higher rates of individuals living alone, and limited access to primary care all contribute to greater reliance on 911 and ambulance services. Calls are increasingly medical in nature, require more time on scene, and involve longer transport, reducing system resiliency.

These trends suggest that traditional EMS deployment and funding models may be insufficient to meet future needs. The region's demographic profile reinforces the importance of innovative approaches, such as enhanced care coordination, community paramedicine, and mobile



integrated healthcare models, that can reduce preventable emergency calls while maintaining access for high acuity emergencies.

Workforce Recruitment and Retention Analysis – Funding and Financial Stability View

Cost of living and affordability, job market and economic stability, potential for growth, safety and community environment, access to amenities and attractions, and location and climate are the primary considerations for individuals in choosing a place to live. The focal region of this EMS study is mainly rural and has been experiencing a steady decline in human services, job market stability, and potential for growth. Many communities have become “bedroom” communities with most individuals commuting for work. The initial post-Covid trend of “work-from-home” is decreasing, and individuals are finding that they need to be in larger areas or return to commuting.

The region draws tourists and seasonal visitors due to the natural beauty and available outdoor recreation. However, the seasonal increase in population has done little to sustain or improve the overall economy, and availability of human services, including healthcare. The loss of maternity services in many areas is a deterrent for younger individuals considering living in the region as they are required to travel, sometimes a considerable distance for these services.

The focus of this study is EMS and throughout sections of the report barriers for recruitment and retention of EMTs and paramedics will be discussed, along with training, staffing, and length of call obstacles. It is notable under funding and financial stability that there are intrinsic barriers to workforce development that are not EMS specific and are part of a greater challenge facing many rural communities. However, one model for recruitment that relates to financial stability is the recruitment of untrained individuals who are then trained and placed by their employers. Some of the burden of earning a living while dedicating time to training to be an EMT or paramedic are alleviated when the training becomes part of the job as opposed to a pre-employment condition.

The challenge in this area for many services is likely to be budgetary with most services operating in a deficit. Opportunities for partnerships, grants, and sustainable funding to allow on-the-job-training to become a paid part of the job should be consistently researched among agencies, municipalities, counties, and other stakeholders to create a more available job market in EMS.



Workforce Development Strategies

Workforce development programs can help EMS agencies address both recruitment and retention by reducing the financial burden associated with training new and existing personnel. Incumbent Worker Training (IWT) may provide eligible employers with financial assistance to train and upskill existing employees, supporting skill development, advancement, retention, and employer competitiveness. For EMS agencies, this strategy could support eligible training that allows existing personnel to strengthen or advance their skills while remaining employed.

Registered Apprenticeship provides another potential workforce strategy by combining paid employment with structured On-The-Job Learning, Related Technical Instruction, workplace mentoring, and progressive skill and wage advancement. An apprenticeship approach may help EMS agencies recruit individuals who are not yet fully trained while providing a structured pathway toward occupational competency and certification. It may also provide advancement opportunities for incumbent workers seeking to progress within the EMS pathway.



Survey and Interview Process

MCM Consulting Group, Inc. (MCM) staff developed a series of survey instruments to collect input from stakeholders across

the six-county study region. Three distinct survey tools were created to reflect the perspectives of key stakeholder groups: Emergency Medical Services (EMS) agencies, Quick Response Services (QRS), and Municipal Officials. Each survey was drafted and refined collaboratively by the project team to ensure clarity, relevance, and consistency across stakeholder categories.

Following finalization, all survey instruments were deployed electronically using the SurveyMonkey platform. A formal invitation letter was distributed to EMS agencies, QRS organizations, municipal leadership, county officials, and other relevant stakeholders throughout the six-county region. This letter included a direct link to the appropriate SurveyMonkey survey, as well as alternative participation options to maximize response rates. These alternatives included telephone interviews, email submissions, and responses via postal mail.

A total of seventy-six unique responses were received from stakeholders representing the six-county EMS system. Respondents included representatives from emergency medical services agencies, fire department-based quick response services, and municipal officials. Survey responses were collected between February 25, 2026, and April 17, 2026. Copies of the survey instruments and the invitation letter are included in this report as Appendices A and B.

In addition to survey responses, targeted interviews were conducted to gain deeper insight into stakeholder perspectives. Interviews were completed with representatives from EMS agencies, QRS organizations, and municipal leadership. These interviews provided additional qualitative data, expanding upon the information gathered through the surveys and offering greater context to identify challenges and opportunities.

The following section presents highlights from each portion of the needs assessment survey results, organized by stakeholder group. Summary statistics and graphical representations are included where applicable to support interpretation of the findings. Detailed, comprehensive survey results are provided on the pages that follow



Survey Results

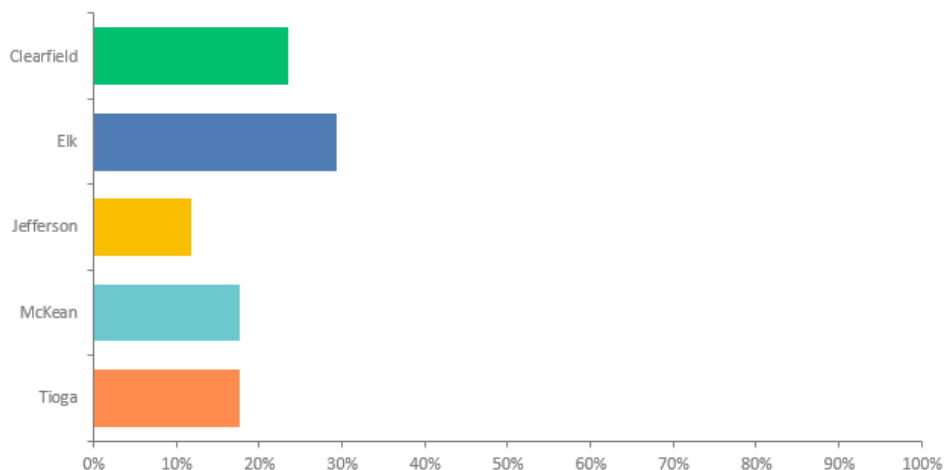
EMS Services

Workforce Solutions NC, PA EMS study - EMS Services



Which 911 center/PSAP dispatches your agency?

Answered: 17 Skipped: 1

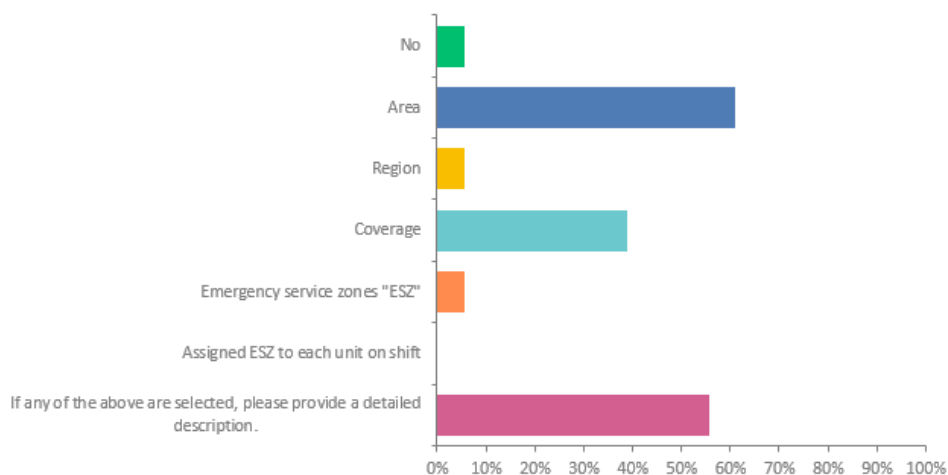


While most EMS agencies are dispatched by the county Public Safety Answering Point (PSAP) in which they operate, crossover between PSAPs does occur. The inability to crew a call often results in a cover agency being dispatched from either an in-county or out-of-county agency. When the necessity to dispatch an out-of-county agency occurs, there are often inherent delays built into the overall time of the call between the initial request for service and the response of an EMS unit. Through careful planning and shared resources among several of the counties studied, those delays have been reduced.



Are you dispatched by zone/area/region/coverage?

Answered: 18 Skipped: 0

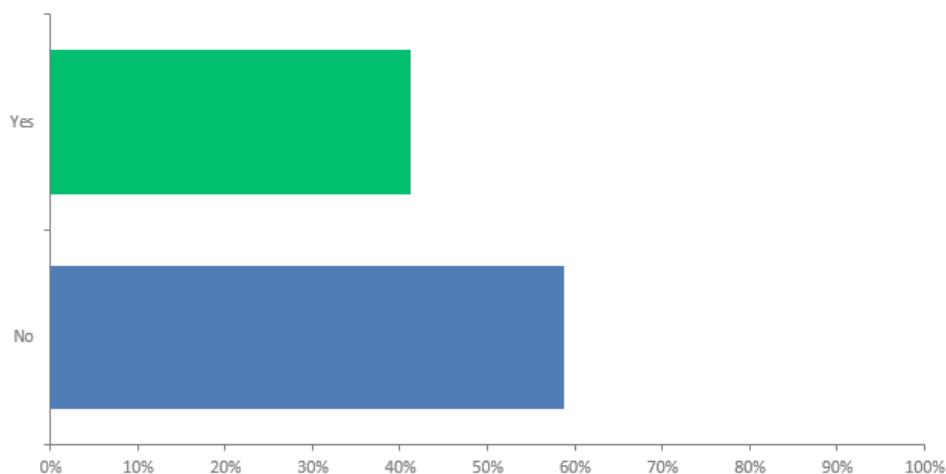


Most agencies (61%) are dispatched based on defined service areas, while others rely on coverage-based (39%) or region-based systems. This indicates that dispatching is largely geographically structured but not standardized across agencies, with varying interpretations of zones and coverage models.



Do dispatch configurations create operational challenges for your service?

Answered: 17 Skipped: 1

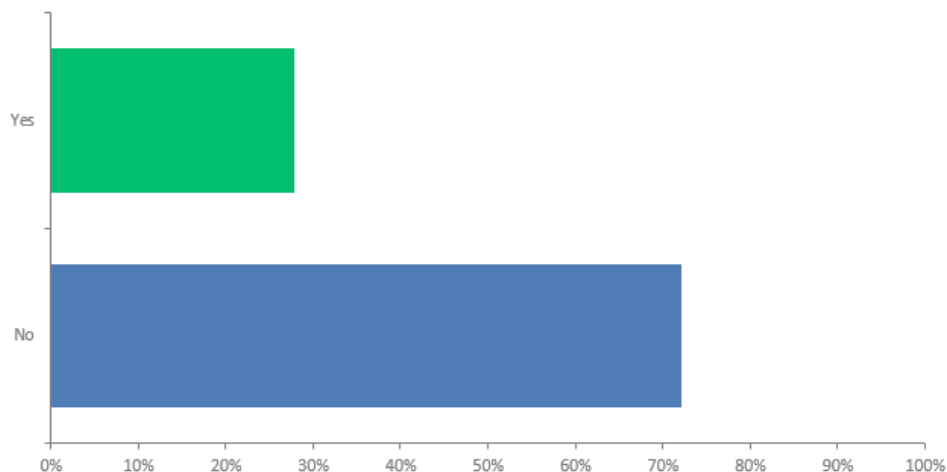


Approximately 41% of agencies report that dispatch configurations create operational challenges, while the majority (59%) do not. This suggests that while many agencies function adequately within current systems, a significant portion experiences what they perceive to be inefficiencies or coordination issues.



Would closest unit dispatch or another form of primary unit dispatch improve system performance?

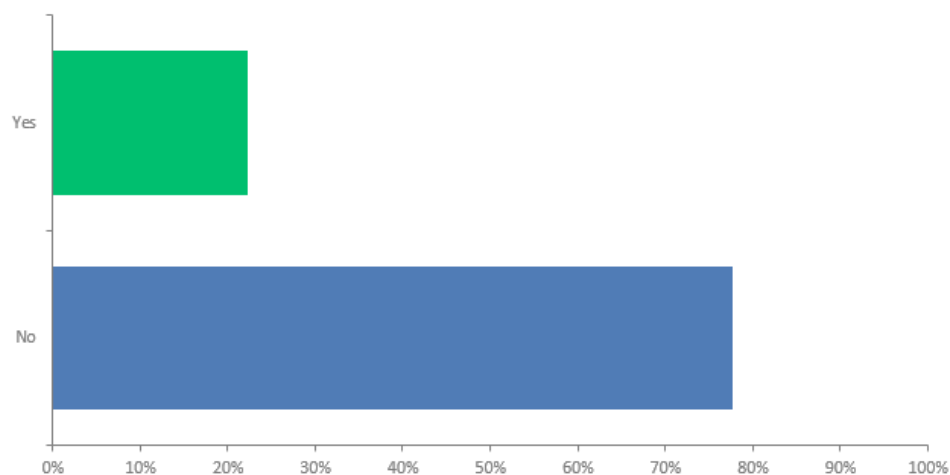
Answered: 18 Skipped: 0



Only 28% of respondents believe a closest, most appropriate unit dispatch model would improve performance. This suggests a general satisfaction with existing dispatch structures or concern that closest-unit models may not align with local realities such as staffing or geography.

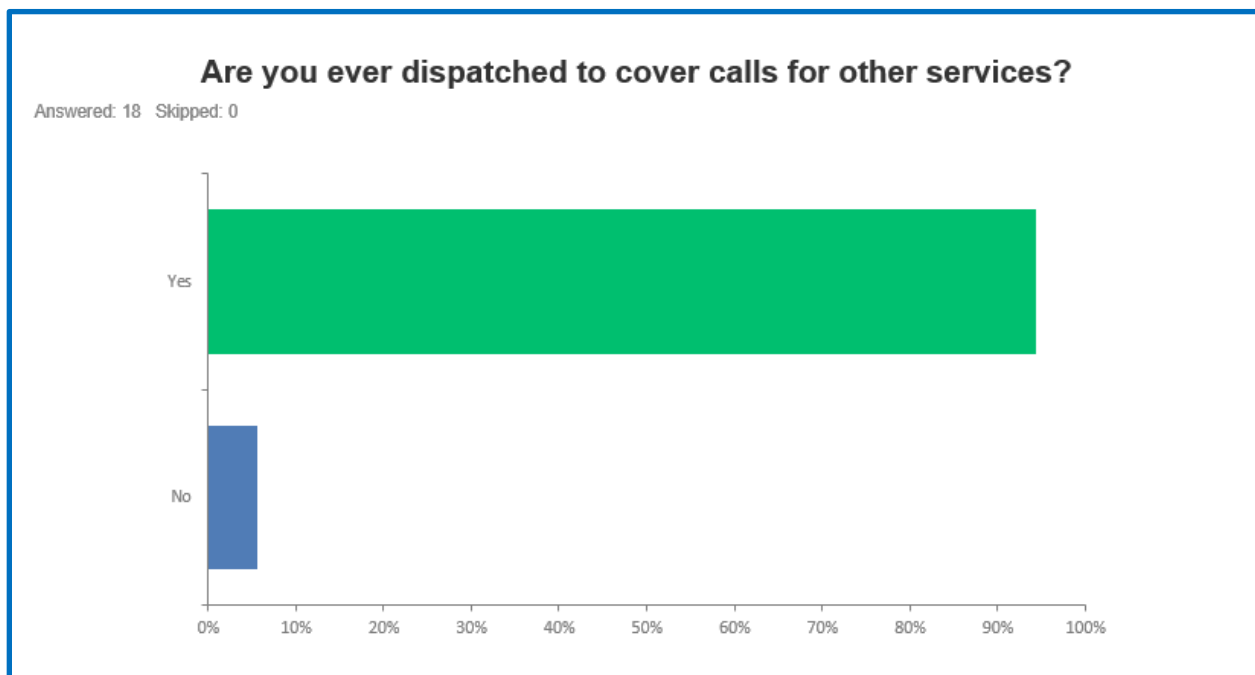
At any time are you dispatched by proximity (closest unit) regardless of zone?

Answered: 18 Skipped: 0





A large majority of agencies report they are not dispatched based on proximity, reinforcing the finding that dispatch systems are primarily based on assigned coverage areas rather than dynamic deployment models.



Nearly all agencies are dispatched to cover calls for other services, demonstrating a high reliance on mutual aid partners. The results also underscore that most areas lack sufficient standalone capacity to cover calls within their assigned primary areas of responsibility.



How many non-transport vehicles are licensed to provide:

Answered: 16 Skipped: 2

#	BLS	#	ALS
1	0	1	0
2	0	2	1
3	2- BOTH AMBULANCES ARE LISTED AS QRS	3	0
4	0	4	0
5	0	5	0
6	1	6	0
7	0	7	0
8	0	8	0
9	0	9	1
10	0	10	0
11	0	11	0
12	4	12	1
13	0	13	1
14	0	14	0
		15	0

How many transport vehicles are licensed to provide:

Answered: 18 Skipped: 0

#	BLS
1	1
2	3
3	2
4	1
5	0
6	2
7	0
8	3
9	2
10	2
11	3
12	2
13	2
14	0
15	1
16	6
17	1



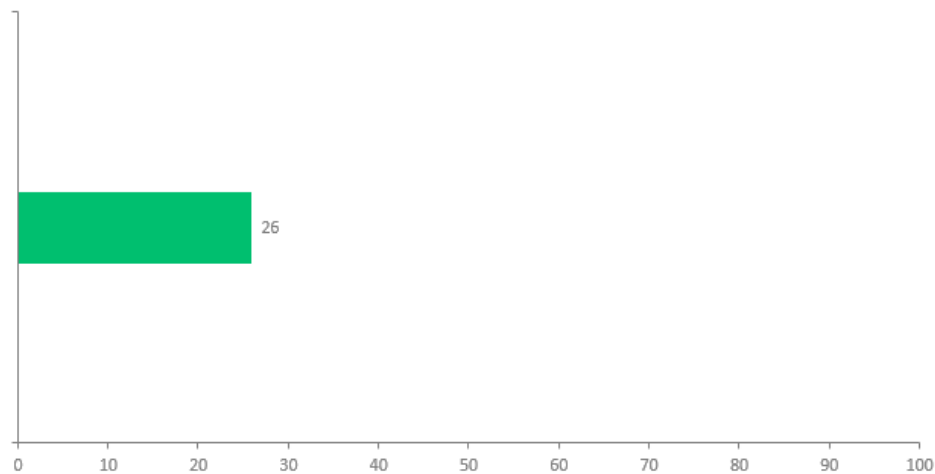
How many transport vehicles are licensed to provide:

Answered: 18 Skipped: 0

#	ALS
1	0
2	3
3	3
4	1
5	0
6	0
7	0
8	0
9	0
10	3
11	7
12	0
13	0
14	4
15	4
16	6
17	0

What is the average number of calls handled per week by your agency?

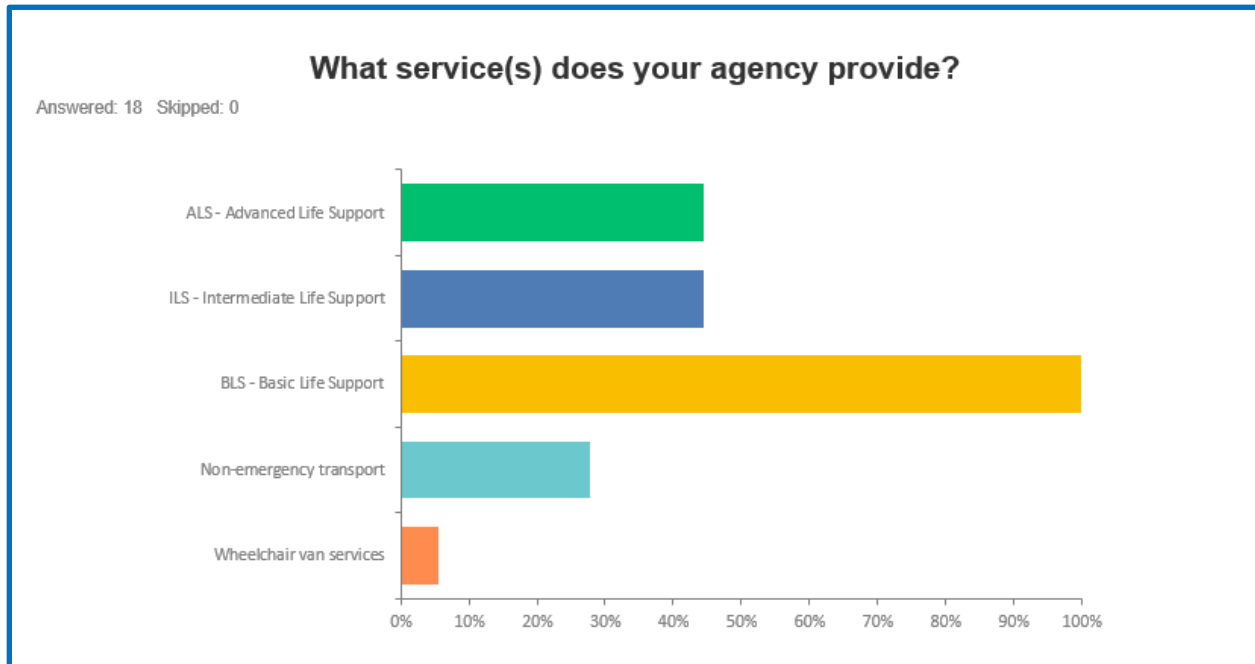
Answered: 18 Skipped: 0



Among all agencies that responded to the survey, an average of 26 calls per week are handled



with the fewest calls handled per week reported at 2 calls, while the most calls handled per week was reported at 100.



**If your EMS station is BLS, which additional BLS protocols have you elected to perform:
(Provide number of providers that can perform services)**

Answered: 12 Skipped: 6

#	EPI PEN	1	26
1	26	2	(5)
2	"CHECK AND INJECT"	3	8
	EPINEPHRINE (4)	4	20
3	0	5	5
4	5	6	all Nasal
5	all Check and Inject	7	x
6	x	8	Y
7	Y	9	23
8	22	10	x
9	x	11	17
10	17	12	x
11	x		
#	NARCAN		



**If your EMS station is BLS, which additional BLS protocols have you elected to perform:
(Provide number of providers that can perform services) Continued**

Answered: 12 Skipped: 6

CPAP

1 26
2 (5)
3 8
4 5
5 all
6 x
7 Y
8 22
9 x
10 17
11 x

OTHER (DEFINE)

1 ALBUTEROL/BRONCHODILATORS (4)
2 Albuterol
3 Albuterol - 20
4 12 lead all
5 12-Lead EKG/Glucometer
6 Glucose 22
7 co- oximeter, 12 lead setup, pulse oximeter,
nebulizer bronchodilators

**Is your EMS station staffed by paid, volunteer, or per diem staff? (Please provide the
applicable number of staff per selection)**

Answered: 18 Skipped: 0

PAID

1 26 2
3 8
4 0
5 6
6 0
7 15
8 38
9 29
10 17
11 15
12 29
13 0

PER DIEM

1 1
2 0
3 0
4 6
5 29
6 0
7 0

VOLUNTEER

1 33
2 13 ACTIVE
3 12
4 100 %

5 12

6 35
7 3
8 21
9 17
10 10
11 100%
12 10
13 2
14 4

OTHER (PLEASE SPECIFY)

1 Other division staff pick up for
call offs and PTO



What is your EMS staffing compliment and levels?

Answered: 18 Skipped: 0

FULL TIME

1	20
2	Paramedic , EMT
3	4 Paramedic, 4 EMT
4	0
5	3
6	8
7	8
8	8
9	4
10	15
11	3 trucks daylight ALS
12	0

PART TIME

1	6
2	Same
3	0
4	3
5	7
6	30
7	21
8	13
9	0
10	0

What is your EMS staffing compliment and levels?

Answered: 18 Skipped: 0

FULL TIME

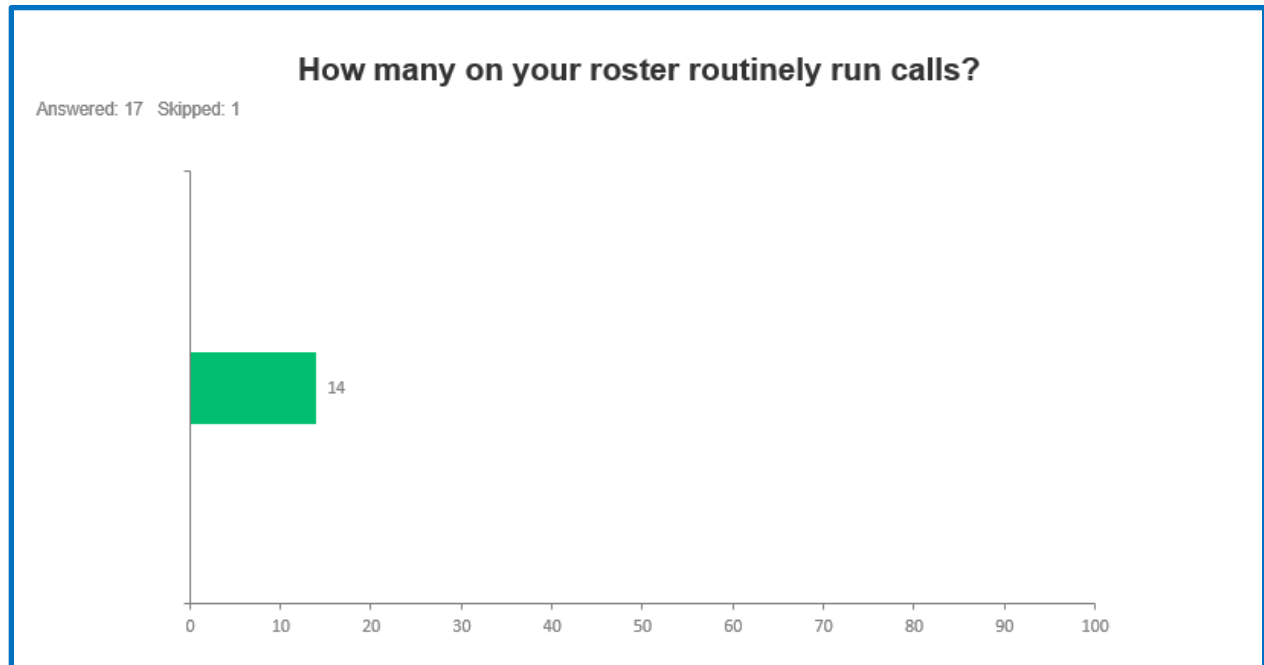
1	20
2	Paramedic , EMT
3	4 Paramedic, 4 EMT
4	0
5	3
6	8
7	8
8	8
9	4
10	15
11	3 trucks daylight ALS
12	0

PART TIME

1	6
2	Same
3	0
4	3
5	7
6	30
7	21
8	13
9	0
10	0



Staffing models vary significantly, combining paid, per diem, and volunteer personnel. Volunteer staffing remains substantial, but many agencies rely on hybrid models due to workforce shortages and the need for flexible coverage.



Agencies average approximately 14 personnel regularly responding to calls. With individual responses ranging from 4 and 28, this relatively small operational workforce highlights the limited staffing depth available to many services.



How many of your personnel work/volunteer at:

Answered: 15 Skipped: 3

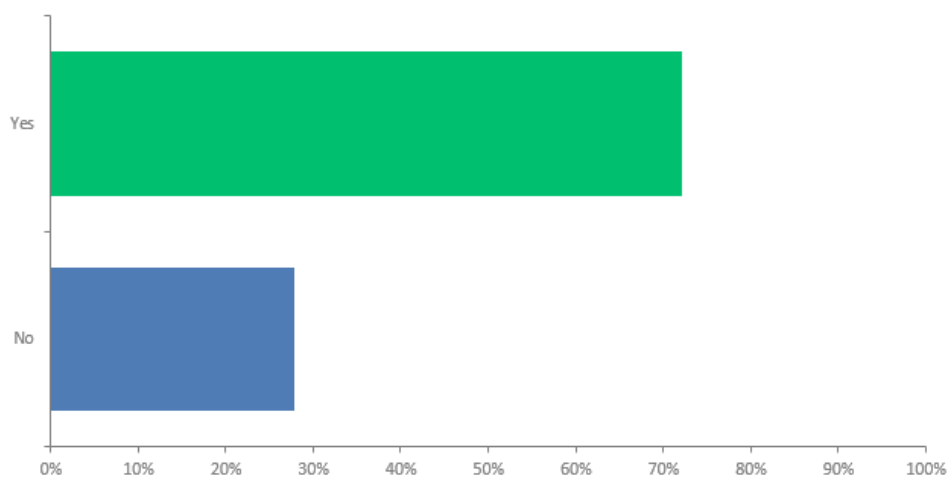
#	MULTIPLE EMS AGENCIES
1	3
2	3
3	1
4	0
5	2
6	4
7	0
8	7
9	22
10	15
11	14
12	0
13	4
14	17
15	0

#	OTHER FORMS OF PUBLIC SAFETY AFFILIATIONS
1	11
2	1
3	0
4	0
5	0
6	0
7	3
8	7
9	0
10	4
11	3 volunteer with fire department

Many agencies reported that personnel frequently work for multiple EMS agencies or participate in other public safety roles. This reflects a shared labor pool and potential risks associated with workforce fatigue and competing work and family commitments.

Does your EMS agency have an established operational staffing plan? If yes, how closely is your agency able to follow the operations plan?

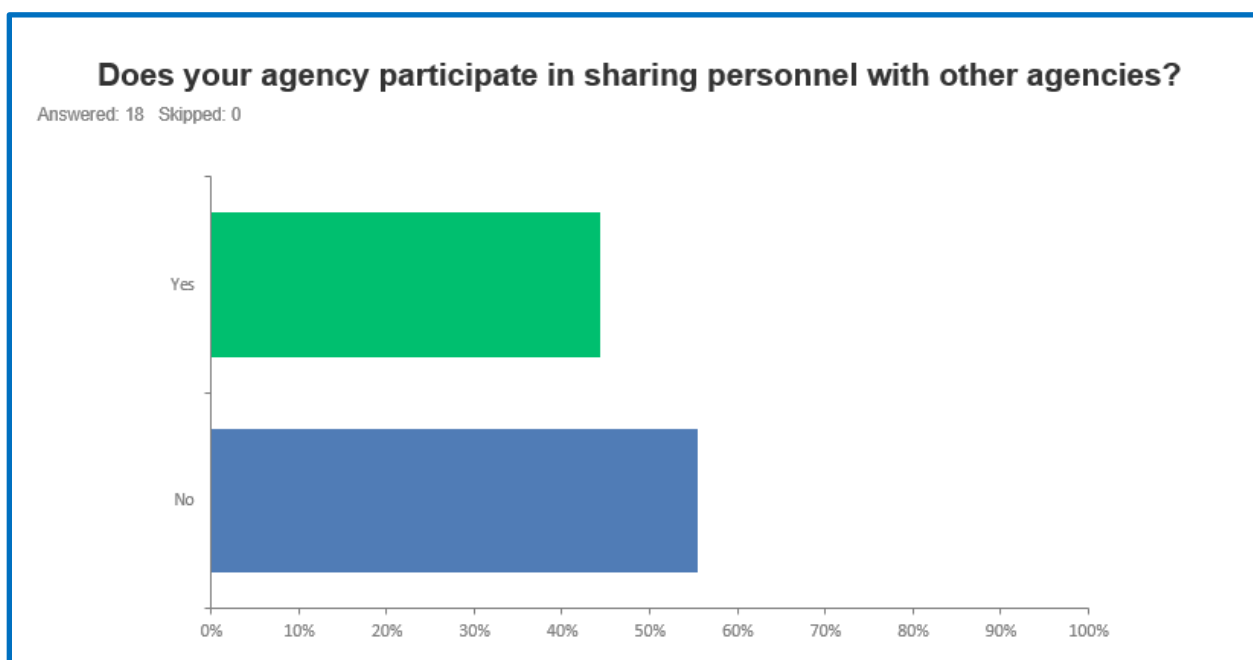
Answered: 18 Skipped: 0





Slightly more than 70% of agencies report having an operational staffing plan. This indicates planning exists, but execution may be constrained by workforce limitations. Several agencies interviewed indicated there is no planned scheduling of crews, instead relying on the availability of volunteers to staff an ambulance once the call has been dispatched. This creates an unreliable method for call coverage and places an increased demand on other agencies within the EMS system.

As noted in the responses received during the interviews with EMS agencies, most report a level of vacancies in their staffing while those with reported sufficient staffing also note that they would hire additional staff if finances permitted.

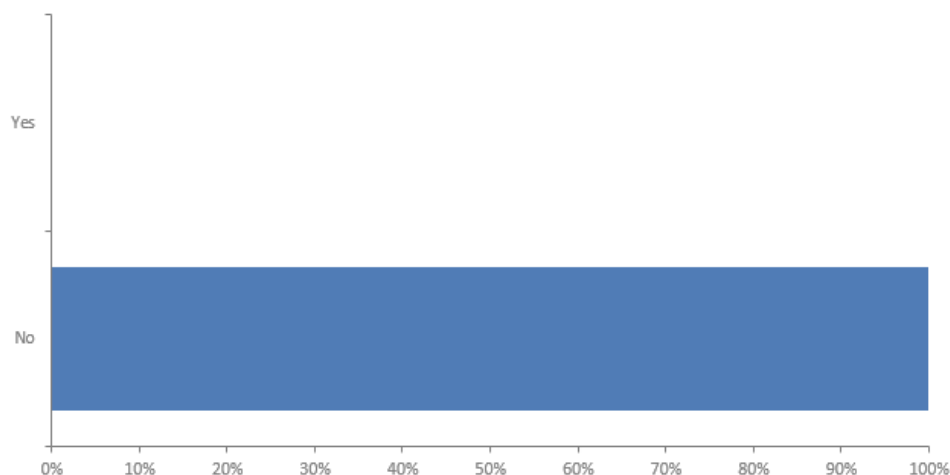


Less than half of agencies report sharing personnel with other EMS organizations. While mutual aid is common, formal staff sharing arrangements seem less developed. Several agencies reported continued efforts or discussions as to how to share staff while others are concerned over insurance coverages, supervision, and availability, among others.



Does your agency use collaborative scheduling, such as alternating agency coverage of multiple response areas?

Answered: 18 Skipped: 0

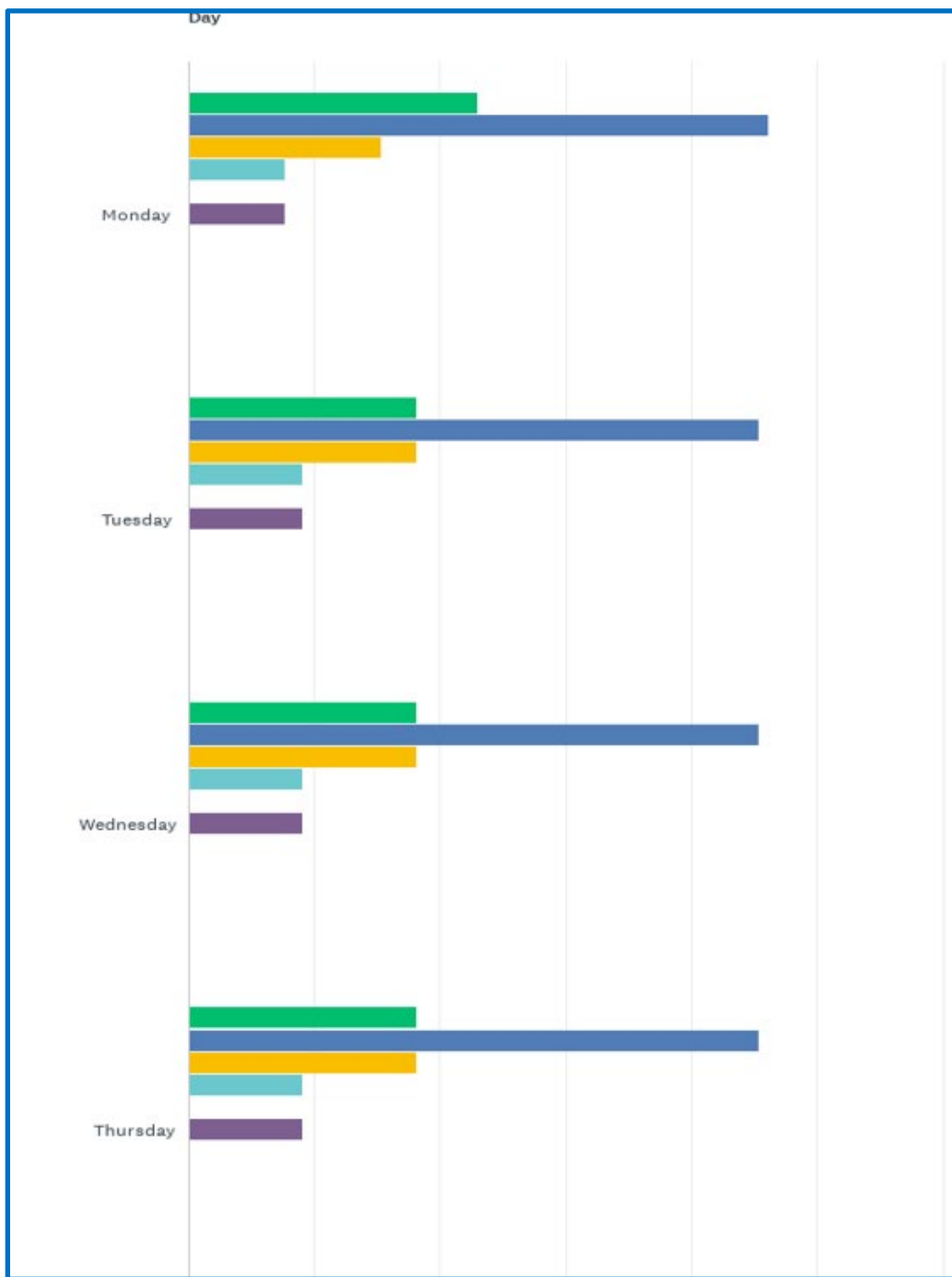


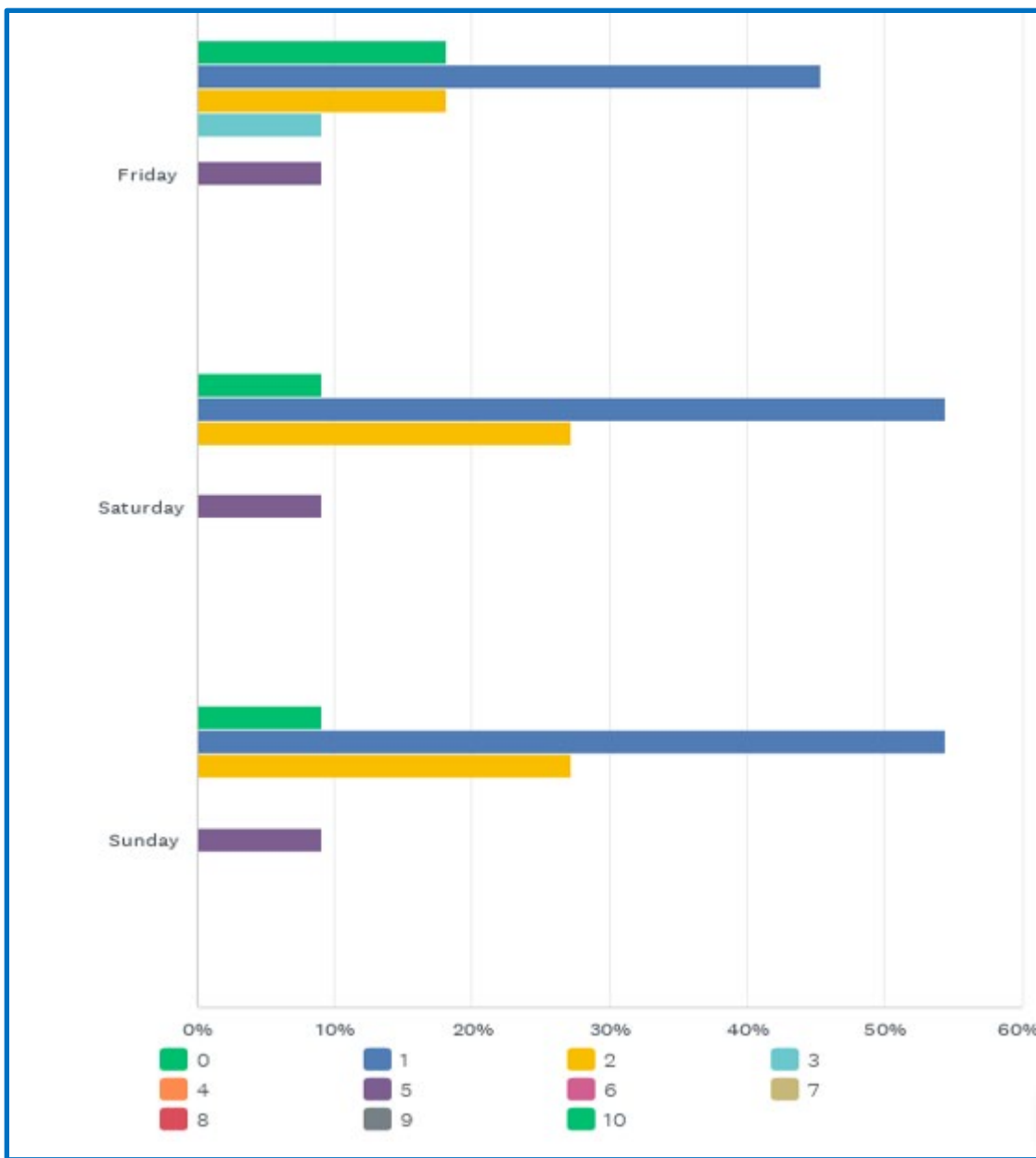
No agencies report using collaborative scheduling models across jurisdictions. This suggests an opportunity for regional coordination in staffing deployment, and a potential opportunity for system improvement.

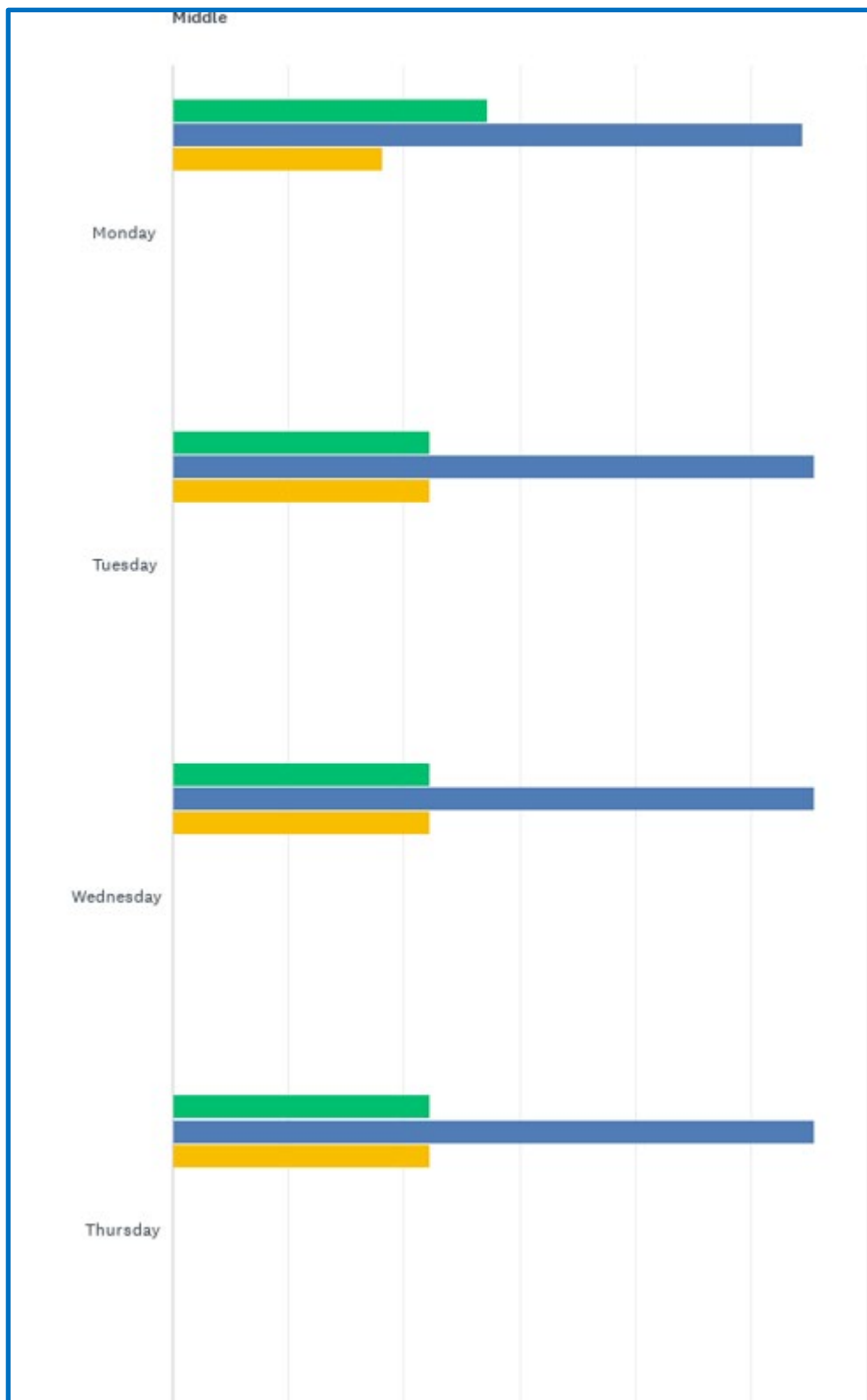


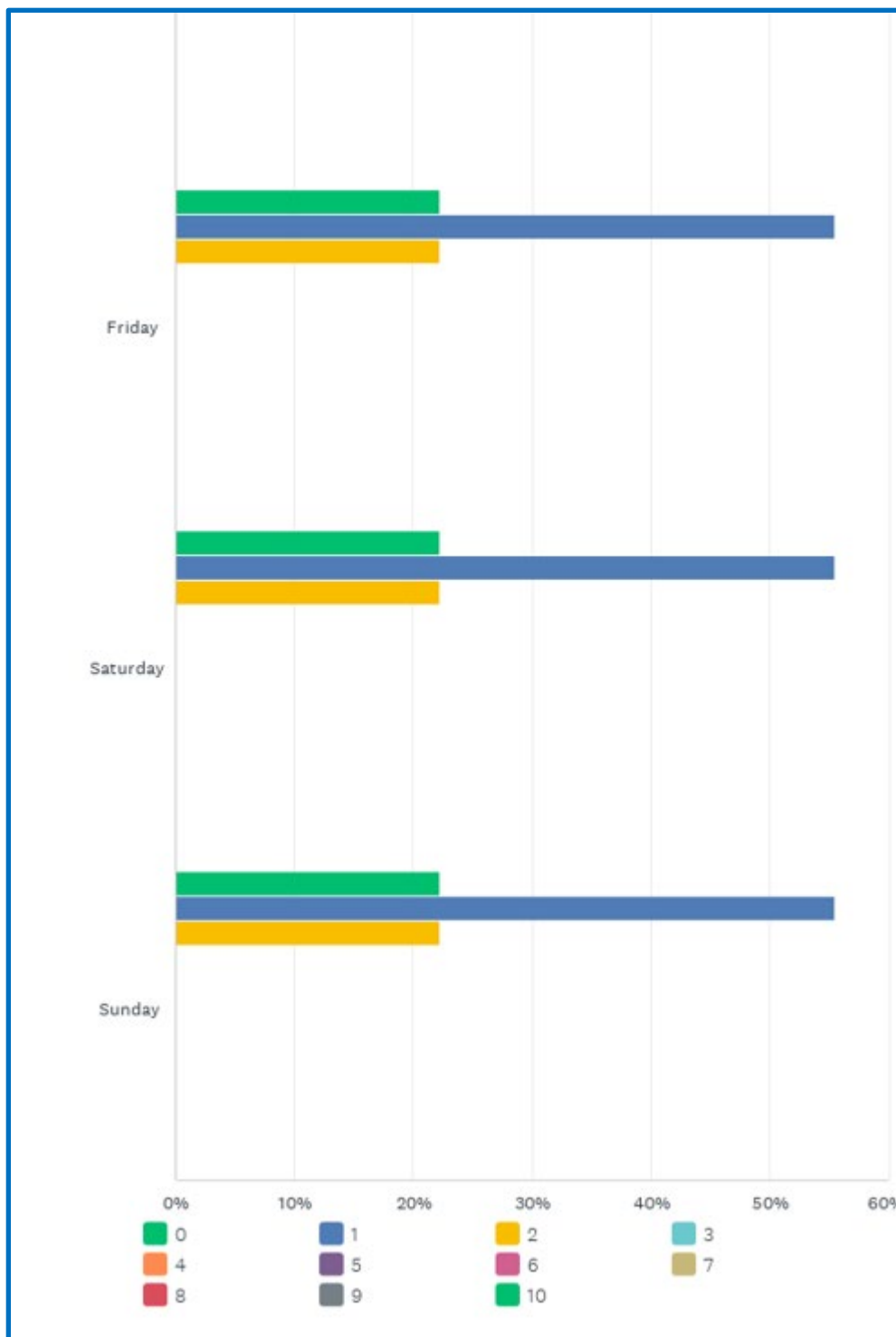
How many BLS crews are scheduled: Day / Middle / Overnight

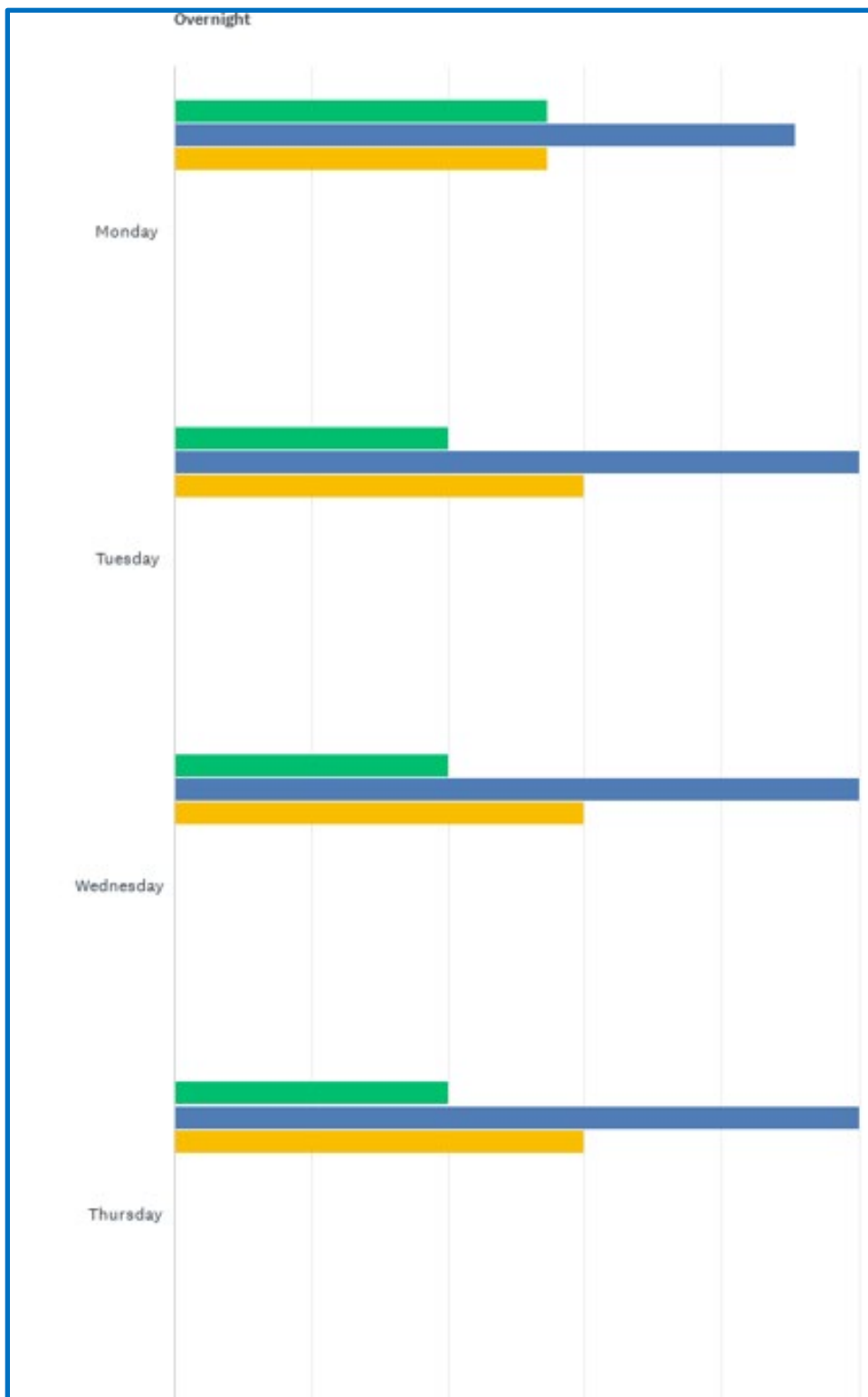
Answered: 13 Skipped: 5

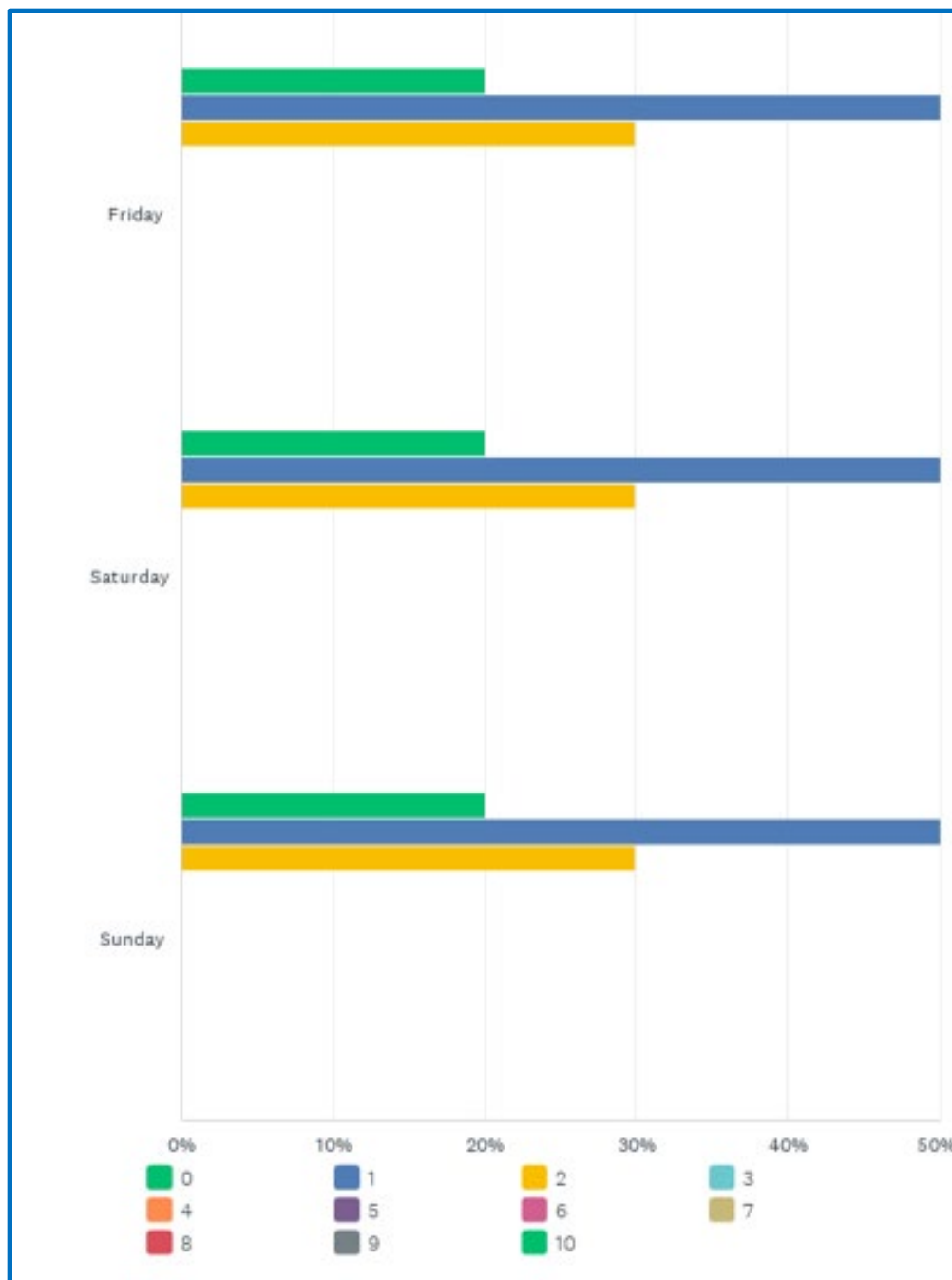








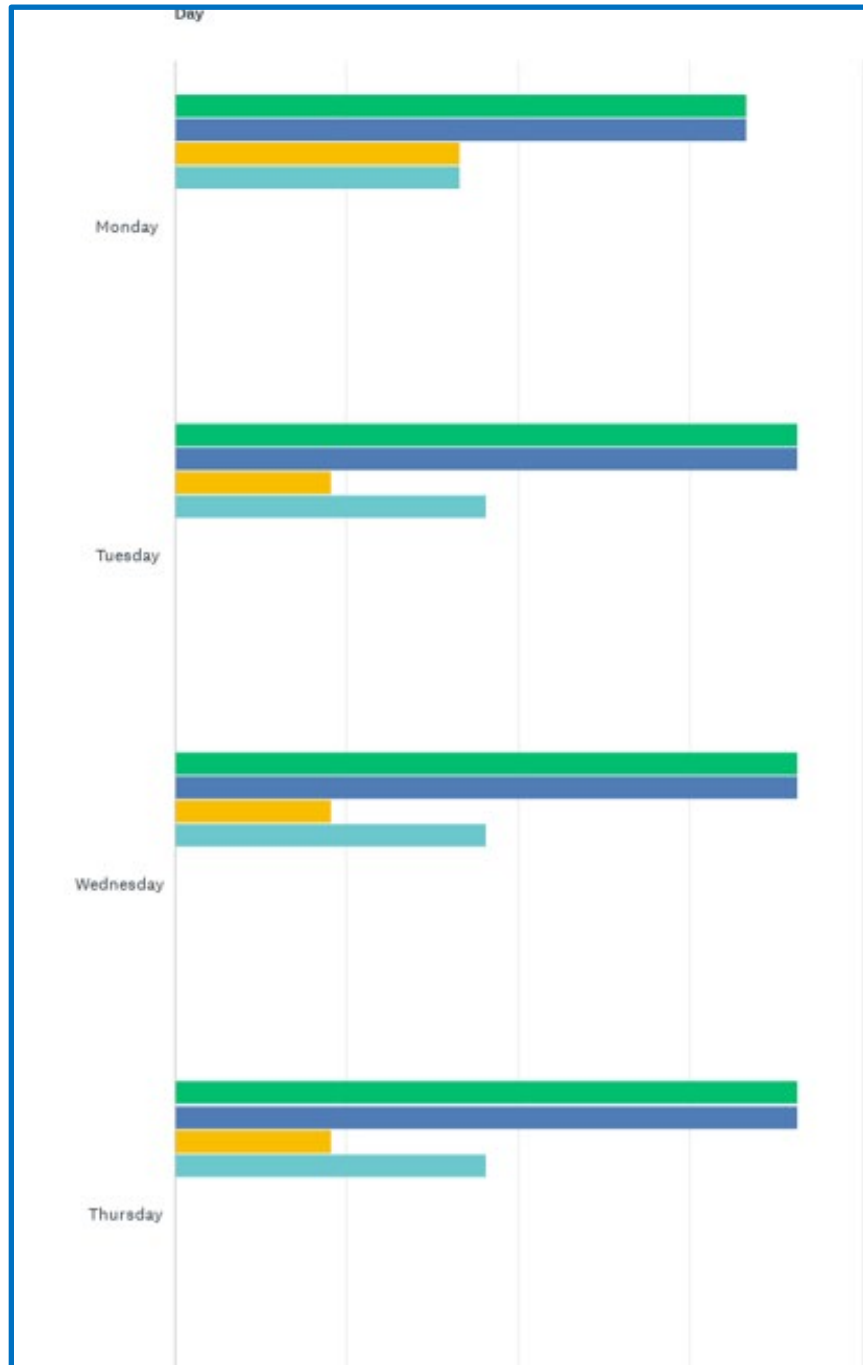


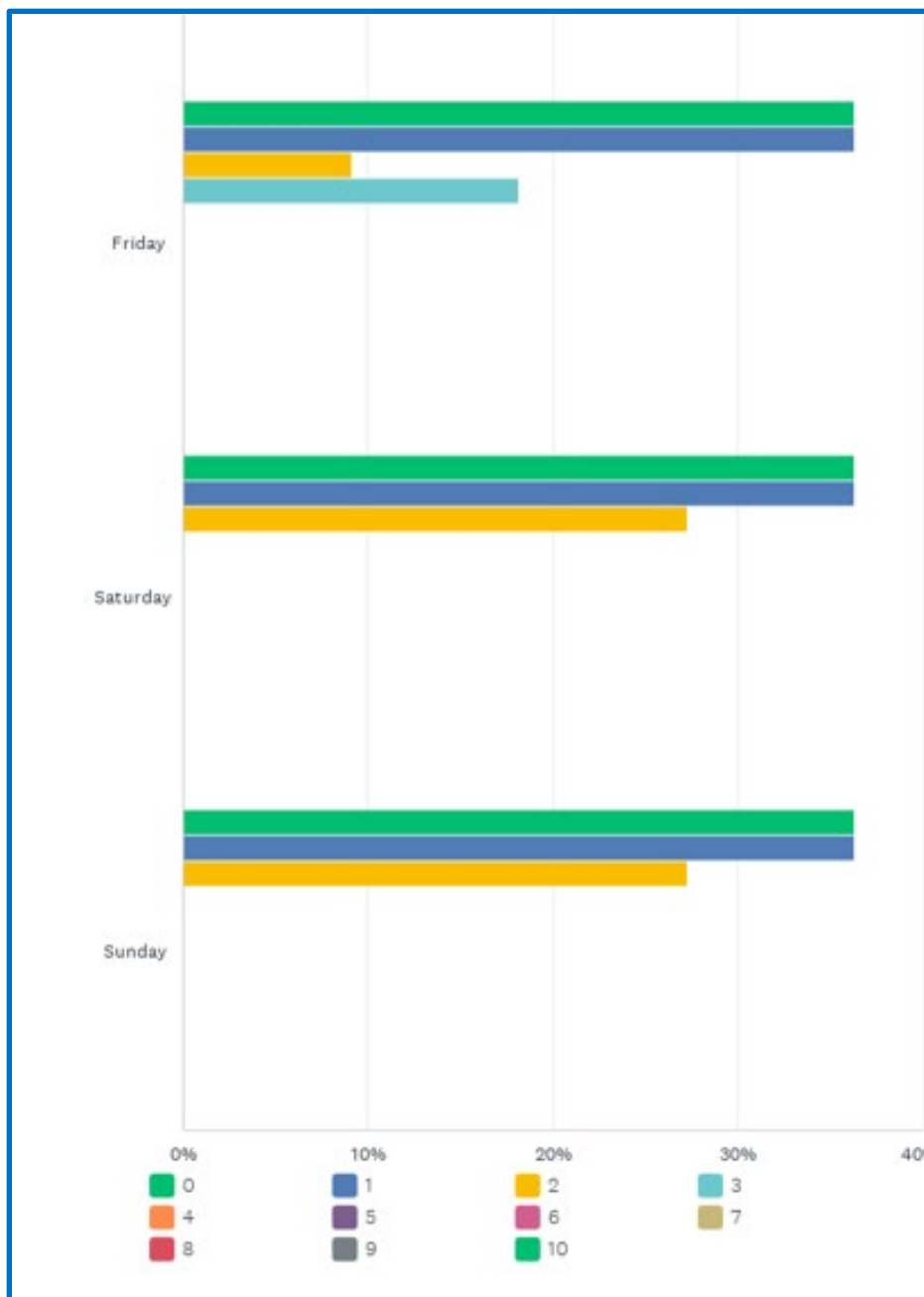


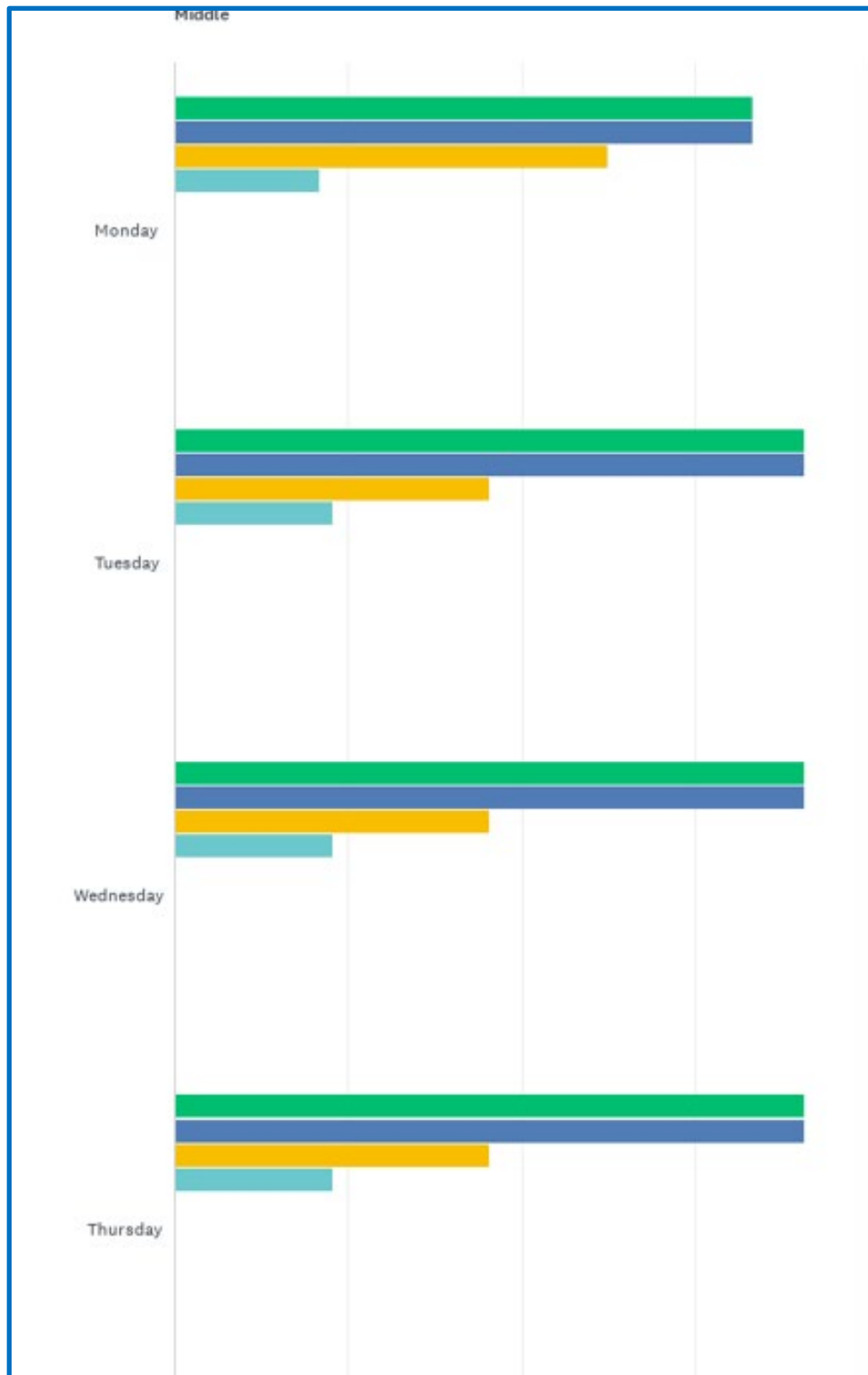


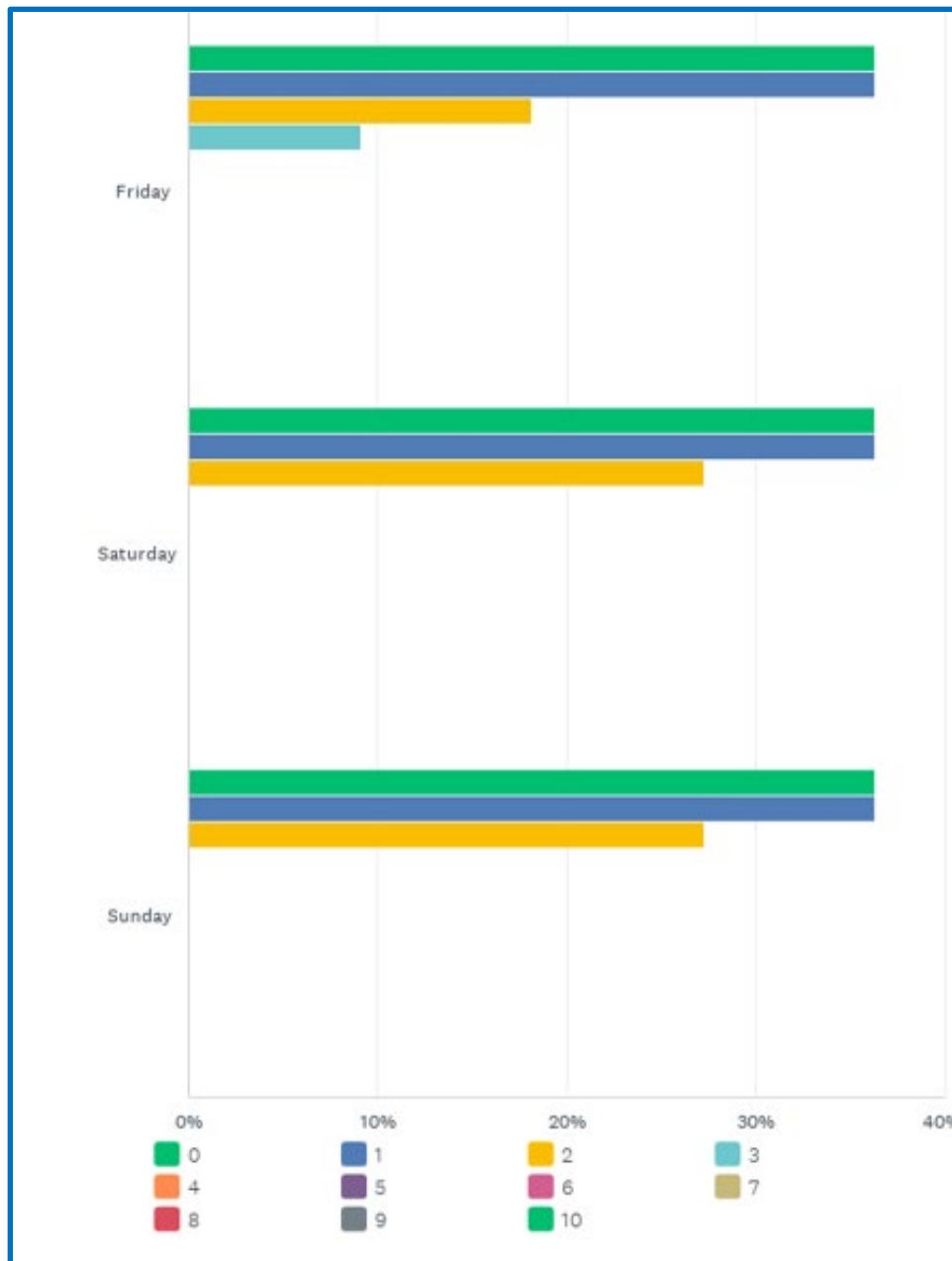
How many ALS crews are scheduled: Day / Middle / Overnight

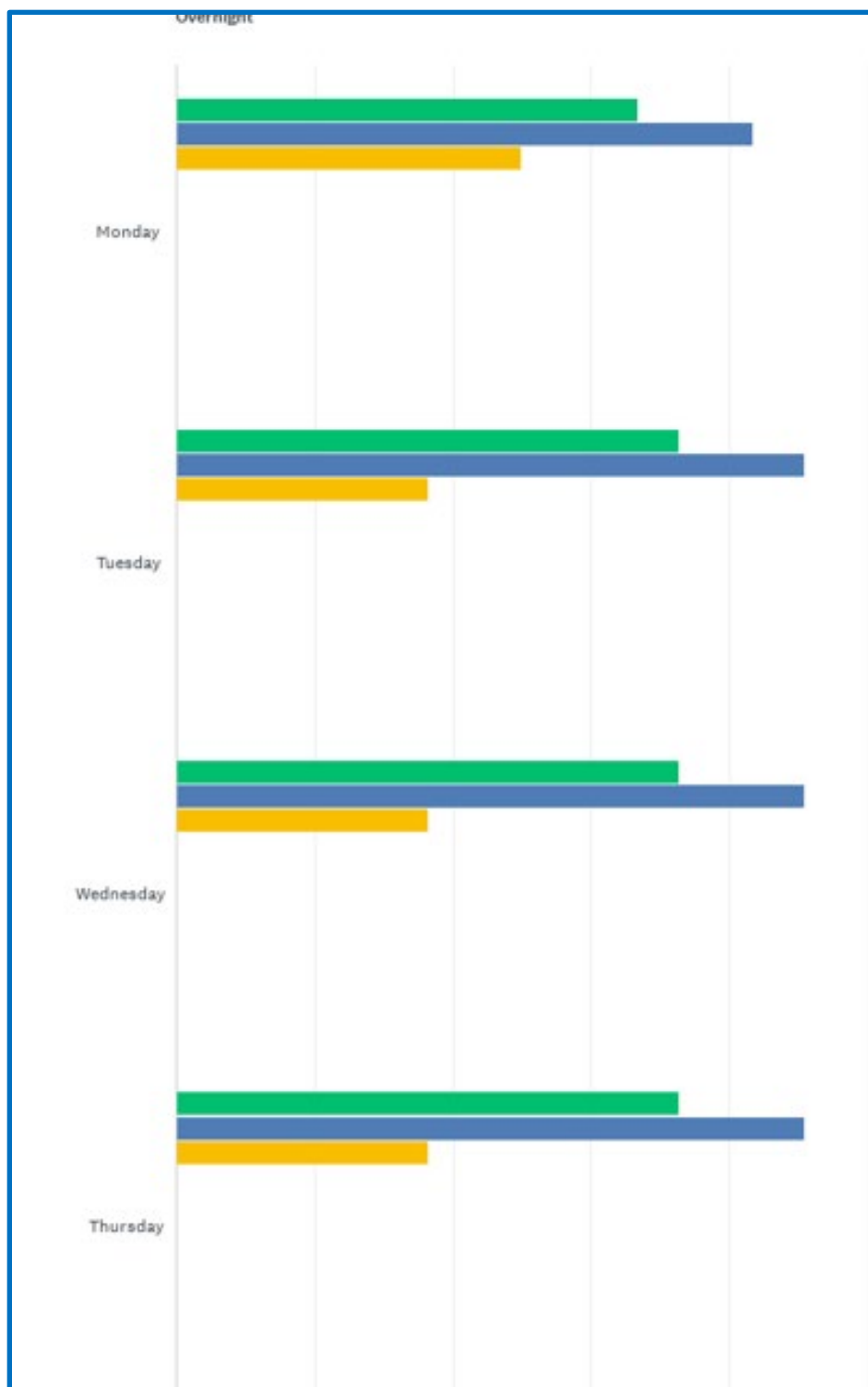
Answered: 12 Skipped: 6

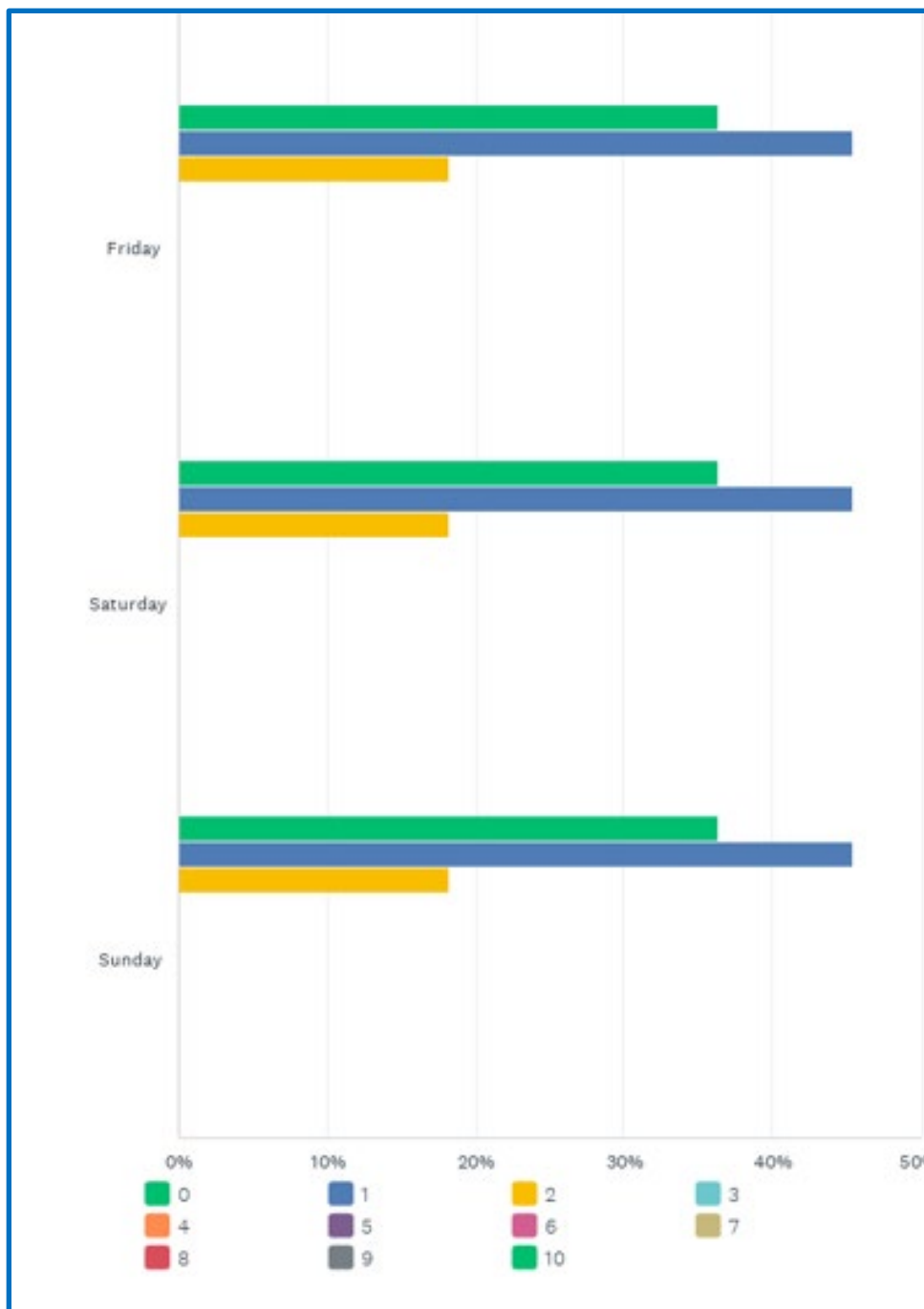








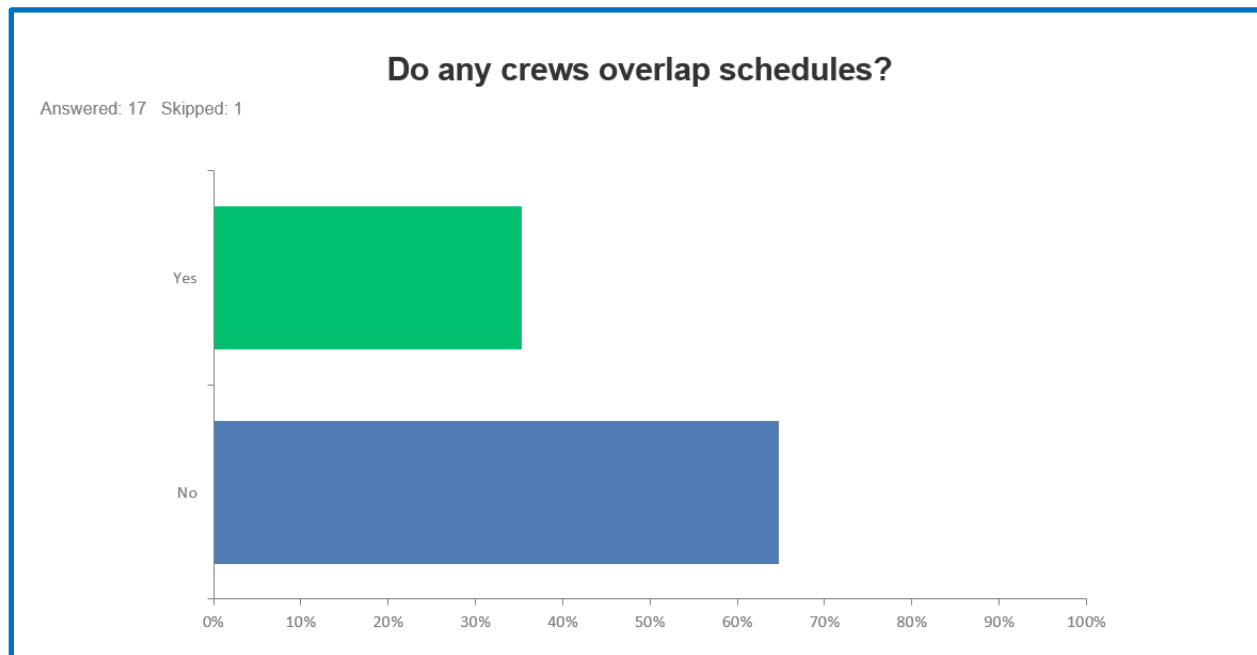




Responses to questions on crew scheduling reflect varied application of scheduling across day, middle, and overnight shifts. Peak hour demands are sometimes difficult to predict, forcing EMS agencies to balance scheduling to meet potential demand against the risk of crew staffing that



increases the cost of readiness per hour in an environment where the additional crew(s) may not be necessary. Conversely, too few crews staffed to cover calls create gaps and increases demand for neighboring EMS agencies to cover calls outside of their primary areas of responsibility.

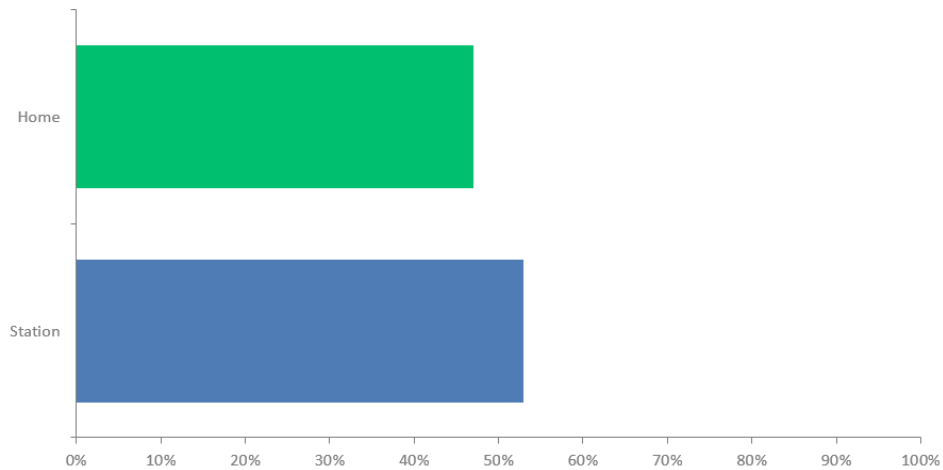


A small number of respondents indicated that they use overlapping crew schedules while the majority do not. Overlapping schedules could reduce overtime, build in surge capacity, and reduce crew fatigue.



When a call is received, where do your EMS crews respond from:

Answered: 17 Skipped: 1

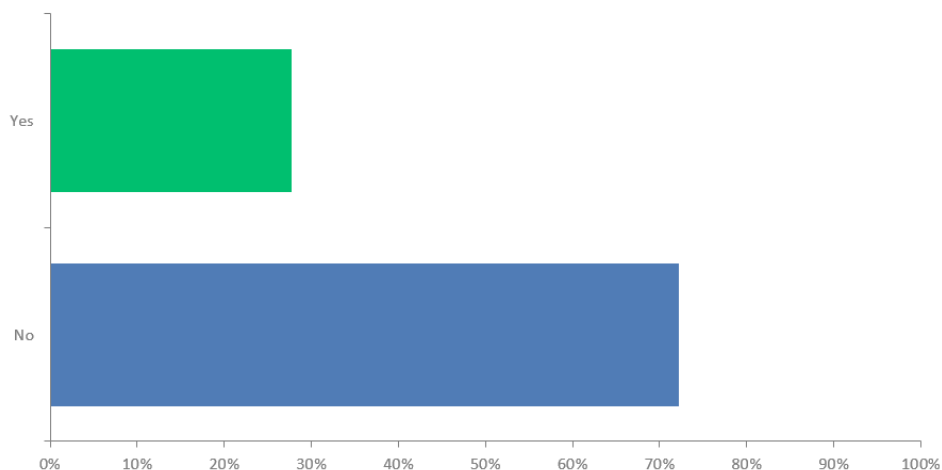


With approximately 47% of agencies relying on personnel responding from home, the EMS response process inherently includes an additional mobilization step. Unlike station-based crews who can respond immediately, home-response systems may experience delays as providers travel to their apparatus before beginning the response to the emergency scene.



Do any of your crews participate in "move-ups" to other station locations during times of high call volume across the county/region?

Answered: 18 Skipped: 0



Only 28% of agencies participate in move-up deployment, which is typically triggered by high call volume or requests for coverage. Most agencies do not utilize proactive system deployment strategies.

What would trigger a unit to participate in "move-ups"?

Answered: 8 Skipped: 10

RESPONSES

- 1 We do not participate in move ups. Our service is very rural with the next due coming from a minimum of 15 miles.
- 2 A request from an outside agency but the request may be rejected if staffing cannot be met and/or maintained in our primary coverage area.
- 3 Situational awareness of our crews listening to other agencies and when requested from another agency.
- 4 Transport to a further away hospital or response outside of our service area.
- 5 If a service is out on multiple calls, they may contact our service to move to a halfway point to stand by if they are unable to crew another call.
- 6 When requested to do so by a home agency.
- 7 High call volumes exceeding the primary agency's capabilities or direct requests
- 8 Mass casualty event or any other event that has second or third due units tied up.



Describe your operation relative to back-up crews and/or call-out procedures for times of high call volume.

Answered: 12 Skipped: 6

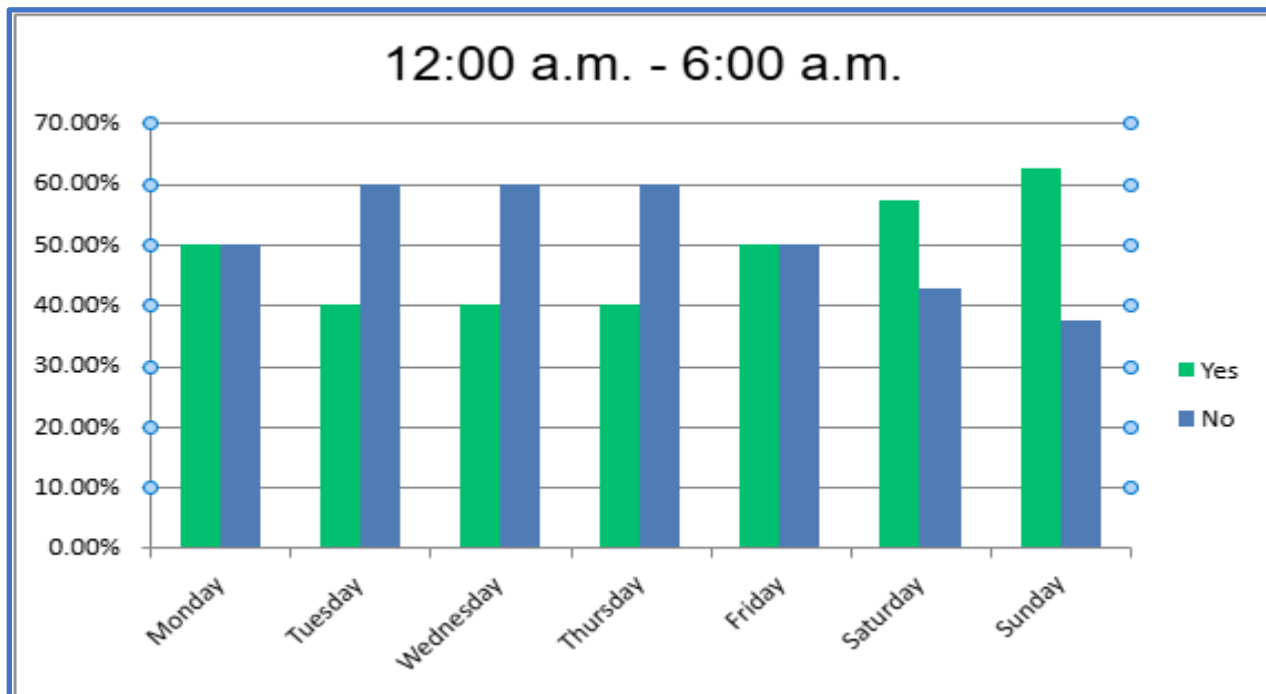
RESPONSES

- 1 Anytime more than one call is received in our first due area, the next due unit and a QRS unit are dispatched.
- 2 We call back off duty personnel. Starting with 2 members and moving up to a whole shift (6) of members, and then to a full call back of all off duty members.
- 3 N/A
- 4 We do not call in, if the Kane crew needs to do a trip, a truck for another division is typically repositioned to Kane.
- 5 Volunteer organization. We respond with an EMT / EMSVO. If there is another call in our area any EMT / EMSVO in our Department can respond.
- 6 Typically no back up crew, all but the three full time employees work other jobs out of the area
- 7 Our volunteers carry their pagers and phones and when a 2nd call is announced they respond if needed.
- 8 The supervisor will call and see if additional staff can come to assist
- 9 For multiple calls I have staff that will respond from home to the station to get a unit. I am also available for second calls while I am at the station. Or we use a messaging system- sending out a message for other crew members to respond or to cover the station
- 10 We have off-duty tones built into the 911 system. Local providers have pager they take home with them. Text alerts add to this, and off duty providers are aware when calls are dispatched near there home or multiple calls are dispatched in a short period of time. Officer-In-Charge also calls providers in from home via cell when needed as well.
- 11 Utilize the PSAP to page out for additional responders
- 12 We page off duty and if available crews come in from home.



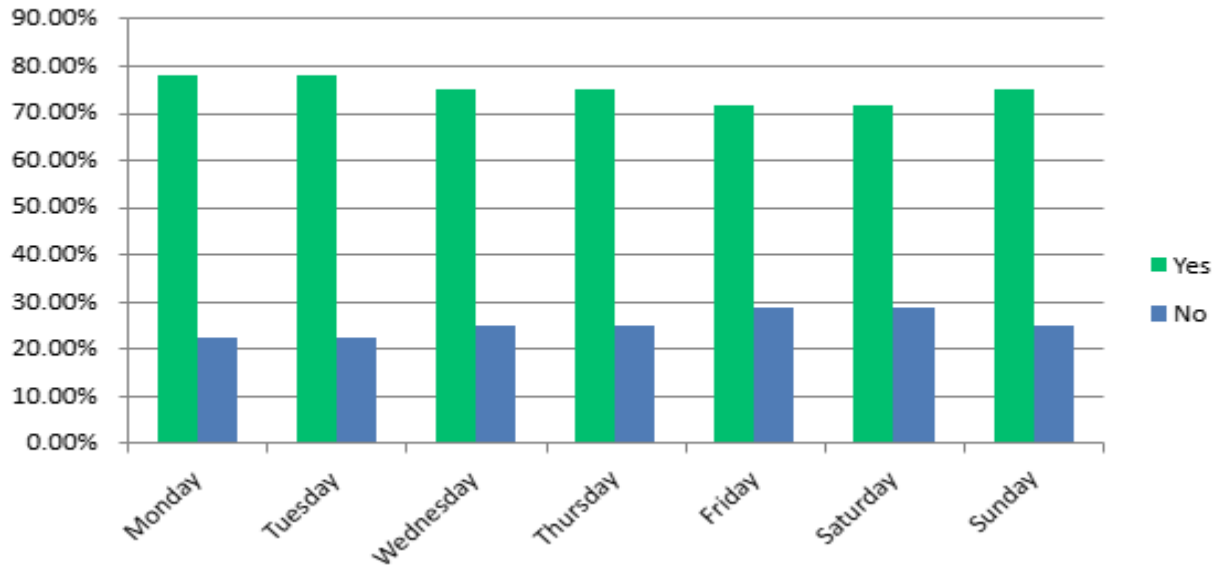
What are the busiest days of the week for your service?

Answered: 9 Skipped: 9

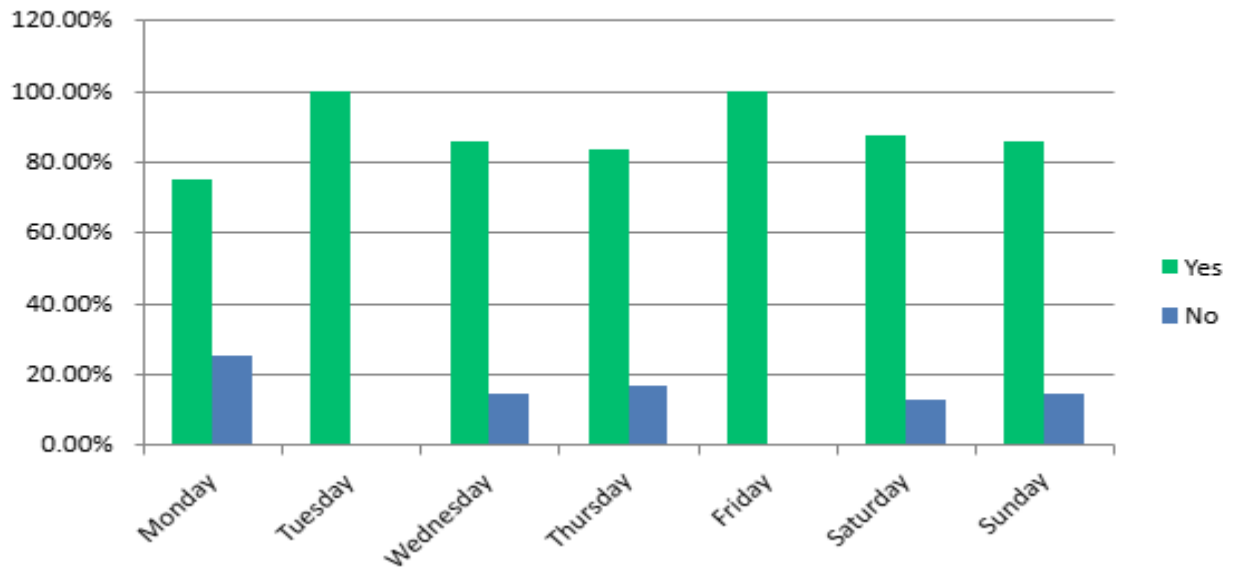


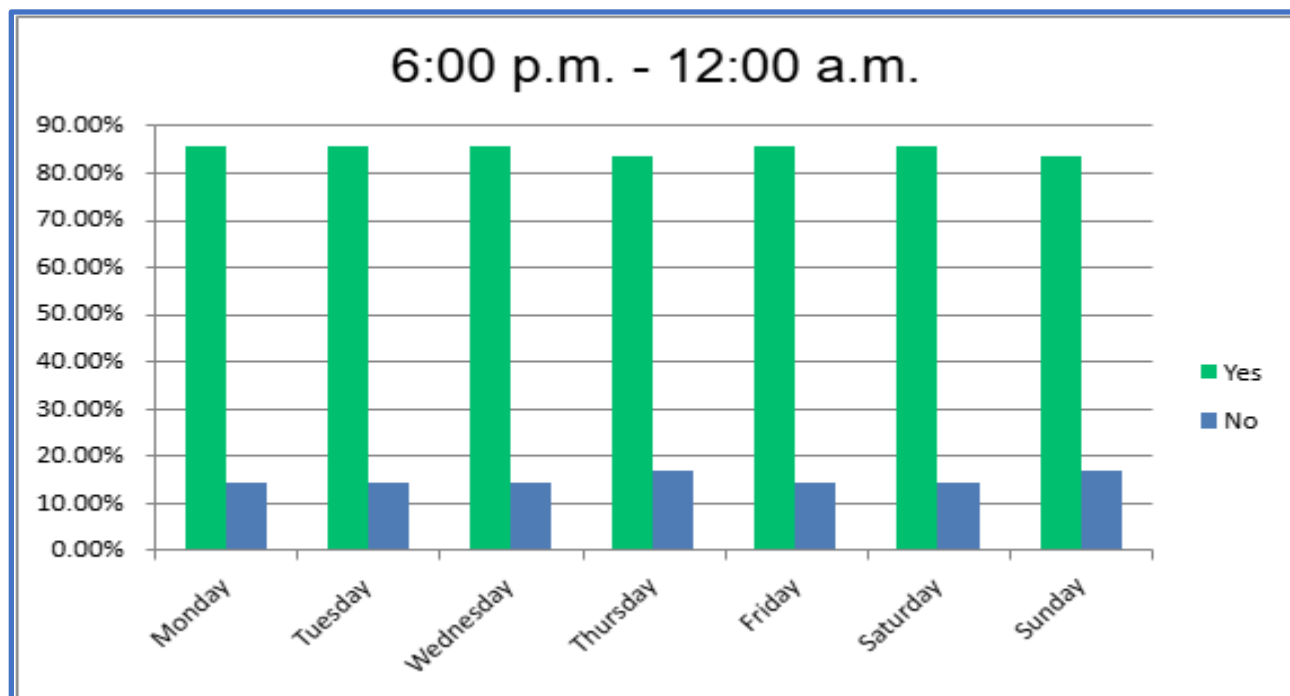


6:00 a.m. - 12:00 p.m.



12:00 p.m. - 6:00 p.m.





Responses indicate variability in busiest days of the week. The agencies overwhelmingly show peak demand for service occurs between 6:00 a.m. and 12:00 a.m. Typically, calls for service increase with population movement to and from work and school, among others, falling mid-morning through the afternoon when the activity again increases.

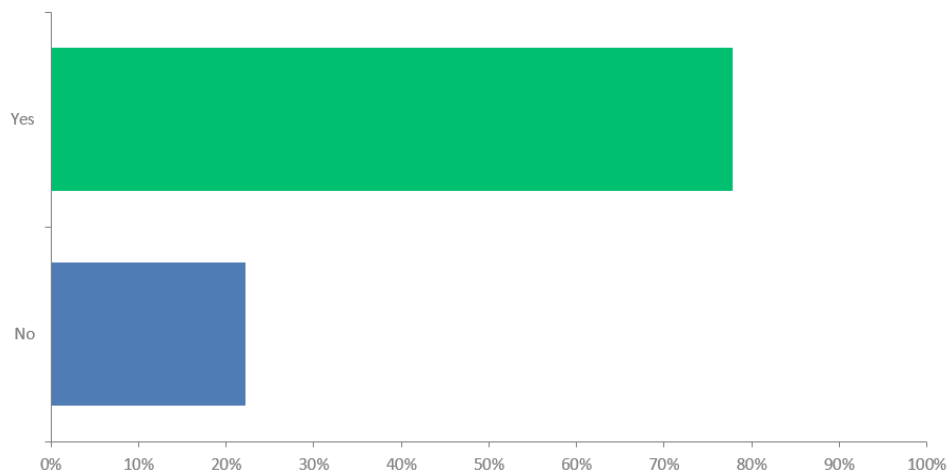


12:00 a.m. - 6:00 a.m.				
	YES		NO	TOTAL
Monday	50.00%	3	50.00%	3
Tuesday	40.00%	2	60.00%	3
Wednesday	40.00%	2	60.00%	3
Thursday	40.00%	2	60.00%	3
Friday	50.00%	3	50.00%	3
Saturday	57.14%	4	42.86%	3
Sunday	62.50%	5	37.50%	3
6:00 a.m. - 12:00 p.m.				
	YES		NO	TOTAL
Monday	77.78%	7	22.22%	2
Tuesday	77.78%	7	22.22%	2
Wednesday	75.00%	6	25.00%	2
Thursday	75.00%	6	25.00%	2
Friday	71.43%	5	28.57%	2
Saturday	71.43%	5	28.57%	2
Sunday	75.00%	6	25.00%	2
12:00 p.m. - 6:00 p.m.				
	YES		NO	TOTAL
Monday	75.00%	6	25.00%	2
Tuesday	100.00%	7	0.00%	0
Wednesday	85.71%	6	14.29%	1
Thursday	83.33%	5	16.67%	1
Friday	100.00%	9	0.00%	0
Saturday	87.50%	7	12.50%	1
Sunday	85.71%	6	14.29%	1
6:00 p.m. - 12:00 a.m.				
	YES		NO	TOTAL
Monday	85.71%	6	14.29%	1
Tuesday	85.71%	6	14.29%	1
Wednesday	85.71%	6	14.29%	1
Thursday	83.33%	5	16.67%	1
Friday	85.71%	6	14.29%	1
Saturday	85.71%	6	14.29%	1
Sunday	83.33%	5	16.67%	1



Are there planned special events within your service area that could increase call volume?

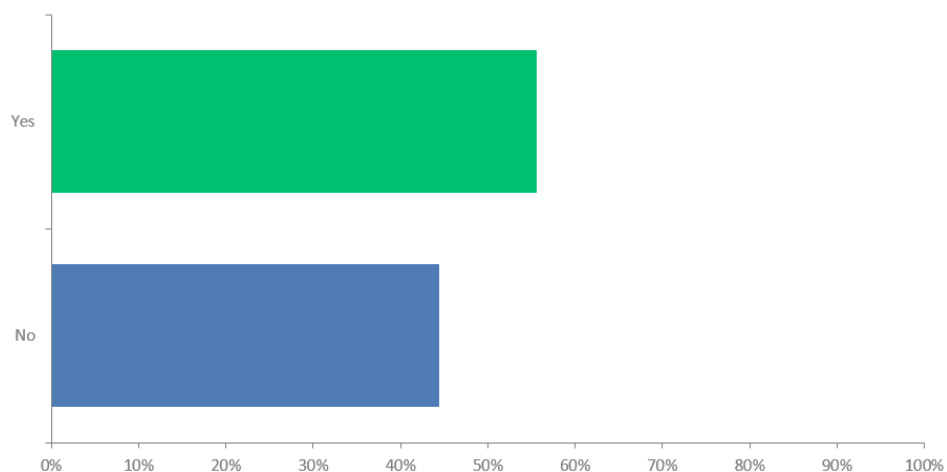
Answered: 18 Skipped: 0



Approximately 78% of agencies experience increased demand from special events, and more than half of respondents increase staffing in response. While some proactive planning exists, not all agencies adjust staffing despite predictable demand.

Do you up-staff for these know busy times?

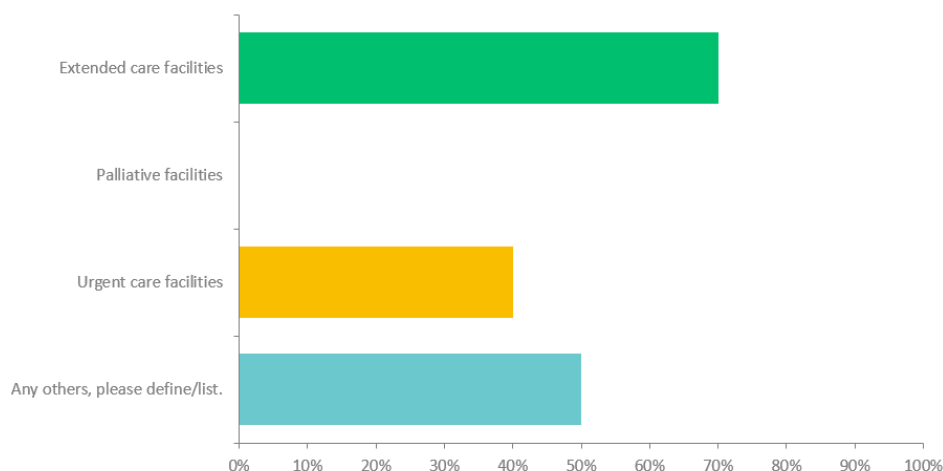
Answered: 18 Skipped: 0





Do you have any high-volume demand facilities in your primary coverage area?

Answered: 10 Skipped: 8

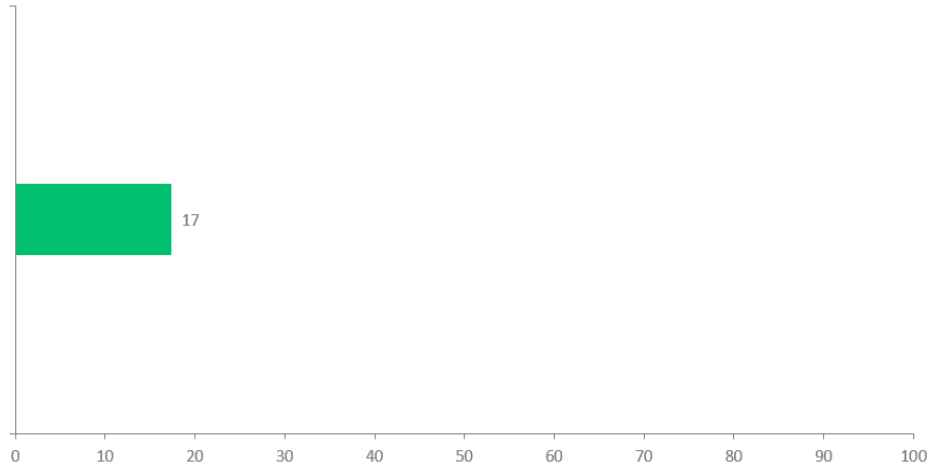


High-demand facilities such as extended care (nursing homes), urgent care centers, and skilled nursing facilities have a disproportionate impact on EMS especially in rural areas. These facilities can generate a steady stream of calls, many of which are low-to moderate-acuity but require transport.



What percentage of calls are initially dispatched as BLS that require ALS/ALS intercept?

Answered: 14 Skipped: 4

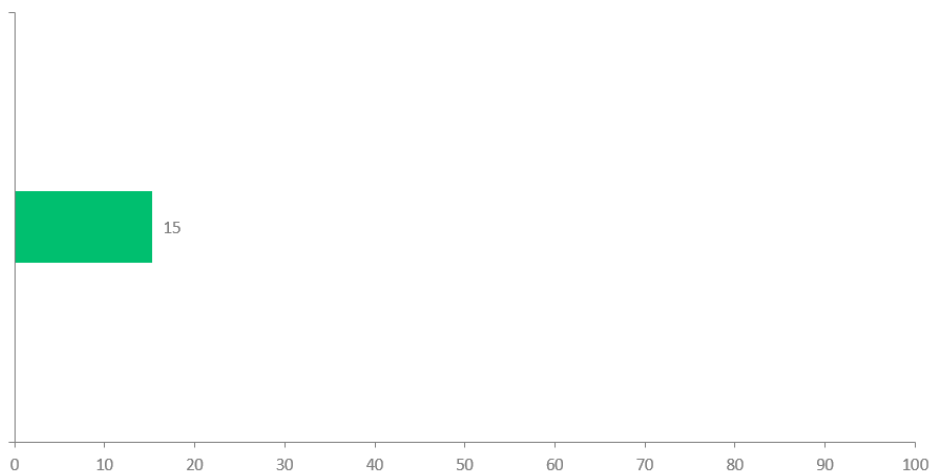


While the average percentage reported is 17, the range varies from 0 to 60 percent of calls among those reporting. PSAP interrogation of the caller to identify the proper resource assignment is critical to reduce over or under utilization of BLS or ALS crews. Additional factors contribute to a post-dispatch change to assignments but nonetheless require an ALS provider assignment to the incident, ultimately in most cases, committing two transportable EMS units for the duration of the call, which increases demand on the remaining available agencies.



What is the percentage of time your EMS agency is out of service?

Answered: 12 Skipped: 6

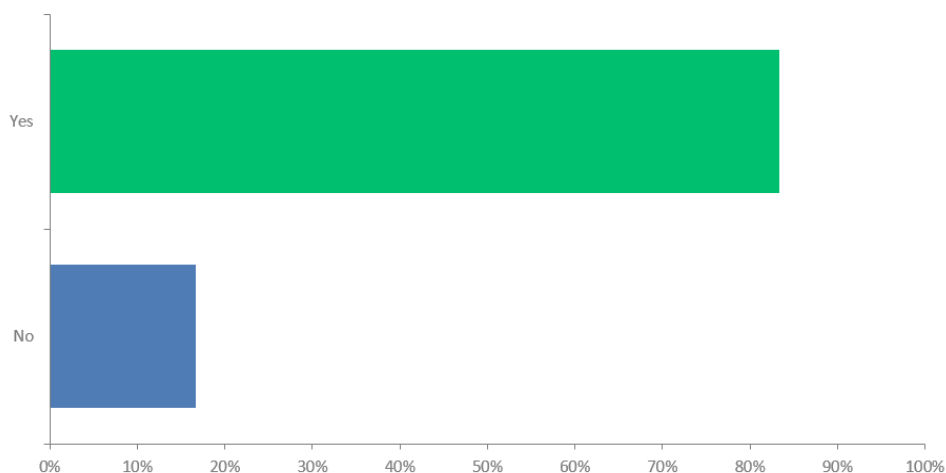


Among respondents, the average percentage of time their agency is out of service seems low, although any amount of time the agency is out of service places strain on the system. Some agencies reported being out of service more than 20% of the time to a high of 75% of the time. It is probable that this number reported is much lower than the actual percentage of time all agencies are out of service. Even when a policy is in force mandating notification when a unit and/or station is out of service, there are always exceptions that are unreported or underreported.



Do you notify the 9-1-1 center when you are out of service?

Answered: 18 Skipped: 0

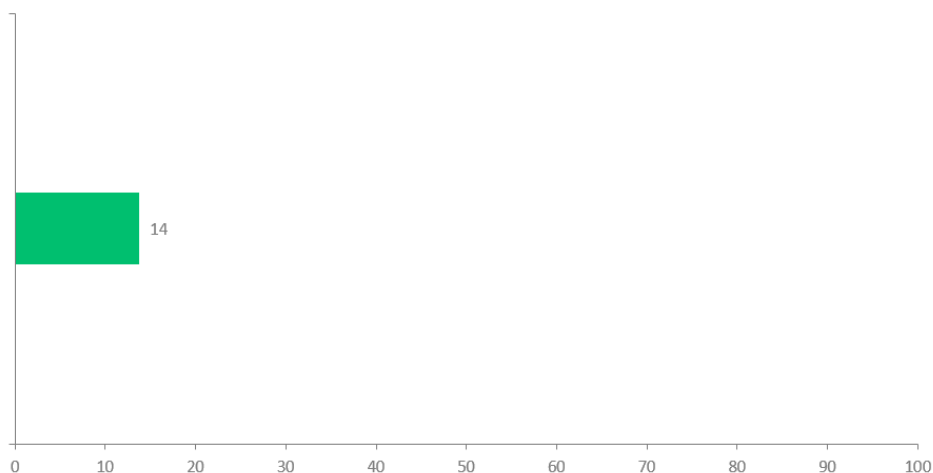


Most agencies report their status to the PSAP in advance while some indicated they do not identify when they are out of service. Coupled with the agencies that do not schedule crews, the telecommunicators potentially must allocate multiple resources to a call for service. Generally, agencies that report their out of service status are provided a “courtesy” tone out while the PSAP simultaneously dispatches the next agency in station order, thereby reducing the time required for an ambulance to respond.



What is the percentage of time your EMS agency is unable to respond to calls?

Answered: 14 Skipped: 4

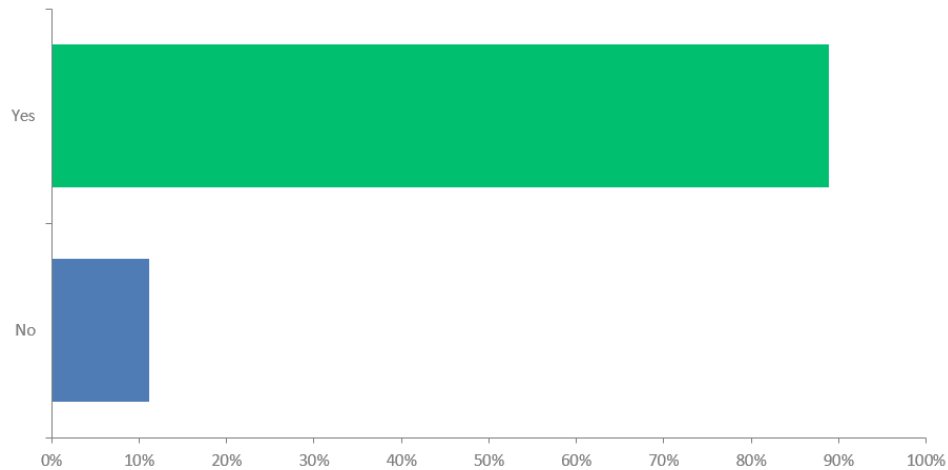


Agencies report being out of service approximately 14% of the time, reflecting significant gaps in coverage and resource availability.



Do you notify the 9-1-1 center when you are unable to respond to calls?

Answered: 18 Skipped: 0



Although there is a high percentage of compliance in reporting when units are unable to respond to calls, anytime a unit is not available for a call and does not notify the PSAP, there are time delays introduced to the response and ultimately, patient care.



If you are a BLS service, how much time does a "typical" call take?

Answered: 12 Skipped: 6

#	DISPATCH TO ON SCENE	#	ON SCENE TO ENROUTE TO HOSPITAL
1	11.35	1	15.75
2	3-15 minutes	2	10-30 minutes
3	10-20	3	10-15
4	8 min.	4	5 min.
5	10 minutes	5	10-20 minutes
6	15-20	6	15
7	10-15	7	15
8	20:43	8	18:48
9	5	9	15
10	there is no typical call in our area	10	N/A
11	N/A	11	10 minutes
12	15-25 minutes depending on where in coverage area		

Call duration varies widely, with transport times often extended (frequently 30–60+ minutes) due to distance to hospitals. These long transport and turnaround times significantly impact unit availability. This pattern points to a system operating near or at capacity, where mutual aid is not just a backup but a routine part of service delivery.



If you are a BLS service, how much time does a "typical" call take? Continued

Answered: 12 Skipped: 6

#	TRANSPORT TO HOSPITAL	#	AVAILABLE TO BACK IN COVERAGE/ RESPONSE AREA
1	44.68	1	35.10
2	3-30 minutes	2	0-5 minutes
3	20-35 (DEPENDING ON HOSPITAL)	3	30-45
4	10 min.	4	10 min.
5	1 hour	5	10 minutes
6	30-50	6	30
7	30-60	7	20
8	32:07	8	20
9	20	9	N/A
10	N/A	10	20 minutes
11	30-45 minutes (closest hospital may be 25-45 miles away, depending)		

If you are an ALS service, how much time does a "typical" call take?

Answered: 10 Skipped: 8

#	DISPATCH TO ON SCENE	#	ON SCENE TO ENROUTE TO HOSPITAL
1	3-15 minutes	1	10-30 minutes
2	N/A	2	N/A
3	3 min	3	5 min
4	Time on task varies to much as other agencies have an impact on this	4	10-20 minutes
5	10 minutes	5	10-20 minutes
6	5-10 minutes	6	20-30
7	10-20	7	15
8	10	8	16min 52sec
9	7min 38sec	9	15
10	4		



If you are an ALS service, how much time does a "typical" call take? Continued

Answered: 10 Skipped: 8

TRANSPORT TO HOSPITAL

- 1 3-30 minutes
- 2 N/A
- 3 15 min
- 4 1 hour
- 5 10-20 minutes
- 6 10-20
- 7 22
- 8 8min 48sec
- 9 5

**# AVAILABLE TO BACK IN COVERAGE/
RESPONSE AREA**

- 1 0-5 minutes
- 2 N/A
- 3 20 min
- 4 10 minutes
- 5 10-20 minutes
- 6 15
- 7 25
- 8 N/A
- 9 8



In the past three (3) years [2023-2024-2025], how often have the calls in your primary territory gone to:

Answered: 11 Skipped: 7

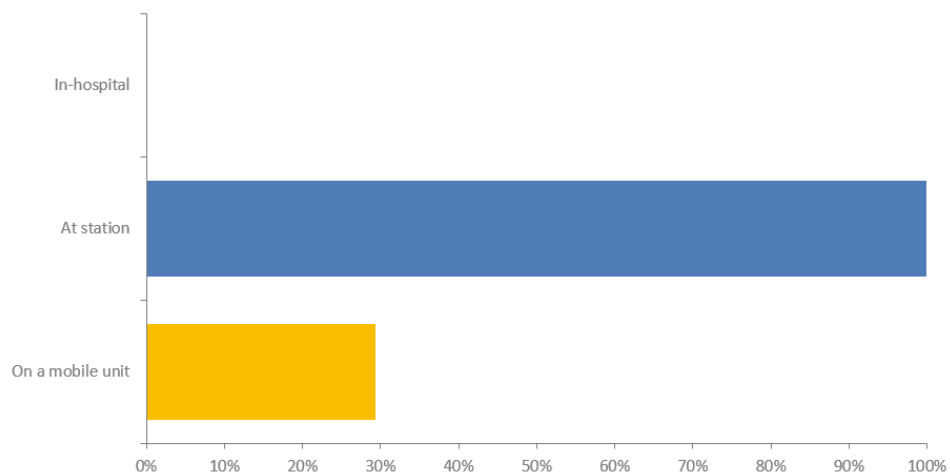
#	2ND DUE	#	3RD DUE	#	4TH DUE DATE
1	35%	1	1%	1	0
2	0	2	0	2	UNABLE TO DETERMINE
3	UNABLE TO DETERMINE AT THIS TIME	3	UNABLE TO DETERMINE AT THIS TIME	3	0
4	8	4	2	4	0
5	75%	5	0	5	none
6	20	6	very few	6	0
7	Only when we are dedicated on another call/standby	7	1	7	0
8	seldom	8	0	8	0
9	18	9	<5%		
10	108				
11	25 % of time				

Calls frequently escalate to second-due agencies, with some reporting significant reliance. Third- and fourth-due responses are less common, but still present, demonstrating tiered response strain. This pattern points to a system operating near or at capacity, where mutual aid is not just a backup but a routine part of service delivery. This places significant strain on the EMS system, as well as on the PSAP staff.



Where do you complete your patient care report (PCR)?

Answered: 17 Skipped: 1





How many and what kind of critical care hospitals do you have in your coverage area?

Answered: 17 Skipped: 1

# HOW MANY CRITICAL CARE HOSPITALS	WHAT KIND OF CRITICAL CARE	# AVERAGE DISTANCE	# AVERAGE DRIVE TIME
1 0 in our coverage area within 1 hour driving time	1 Trauma Level II, Primary Stroke Center	1 45 2 30 MILES 3 20 miles	1 50 2 30-35 MINUTES 3 15 min
2 1	2 LEVEL 2 TRAUMA CENTER	4 50 miles	4 1 hour
3 1	3 Trauma 2	5 20 miles average, as much as 40+ at far end of area	5 Avg 30 min
4 0	4 Level II Trauma, Stroke Center, Heart Center, Lung Center, Cancer Center	6 20	6 25
5 0	5 Trauma	7 35 miles	7 45-50 minutes
6 1	6 0	8 20-35	8 45
7 0	7 Level 2 Trauma Center	9 20 miles	9 20 minutes
8 1	8 Trauma Center Level two and four/Cardiac care	10 65 miles	10 AVERAGE, ONE HOUR AND A HALF
9 0	9 trauma	11 18.6 miles	11 22 minutes
10 1	10 Level 2 Trauma Center, Primary Stroke Center, Primary Heart Center	12 7 miles	12 10 minutes
11 2	11 Critical Access Hospital facility	13 30 plus	13 30 to 60 depending on location of call, type of injury and weather.
12 1			
13 1			
14 1			
15 1			
16 0			
17 2			

Access to critical care hospitals is limited, with transport distances often ranging 20–65 miles and travel times up to 1.5 hours. This significantly increases EMS workload and reduces system availability.

If there are diagnosis-specific protocols for transport-to-care facilities, please identify the following:

Answered: 12 Skipped: 6

# FACILITY NAME/DIAGNOSIS SPECIFIC CARE PROVIDED	# AVERAGE DISTANCE	# AVERAGE DRIVE TIME
1 PH Dubois/Trauma, PH Dubois/Stroke, Mount Nittany Med Center/Stroke	1 45	1 50
2 Olean General Cardiac/Stroke	2 25 miles	2 30 minutes
3 PENN HIGHLANDS DUBOIS - LEVEL 2 TRAUMA AND STROKE CENTER	3 30 MILES	3 30-35 MINUTES
4 Penn Highlands Dubois	4 51 miles	4 1hr 15min
5 Penn Highlands Dubois/Trauma, Cardiac/Neurosurgery, Neurology, Pulmonology	5 50 mile	5 1 hour
6 Trauma Patient's	6 35 miles	6 45-50 minutes
7 Penn Highlands Dubois/Trauma 2 and Cardiac Care-Indiana Regional Medical Center/ Trauma level 4 and Cardiac Care	7 24miles	7 35
8 Trauma Center	8 52	8 1 hour 10 min
9 TRAUMA, CARDIAC	9 65 MILES OR 50 MILES	9 ONE AND ONE HALF TO ONE HOUR
10 Not sure what is being ask.	10 35 miles	10 55 minutes
11 Penn Highlands Dubois, Trauma, Cardiology, Neurology, Surgical, Specialty Care resource center	11 22 miles	11 25 min
12 Penn Highlands Dubois/ Trauma and cardiac		



What is the closest/farthest critical care facility to which you transport patients? (Provide average time spent from leaving scene to back in coverage/response area).

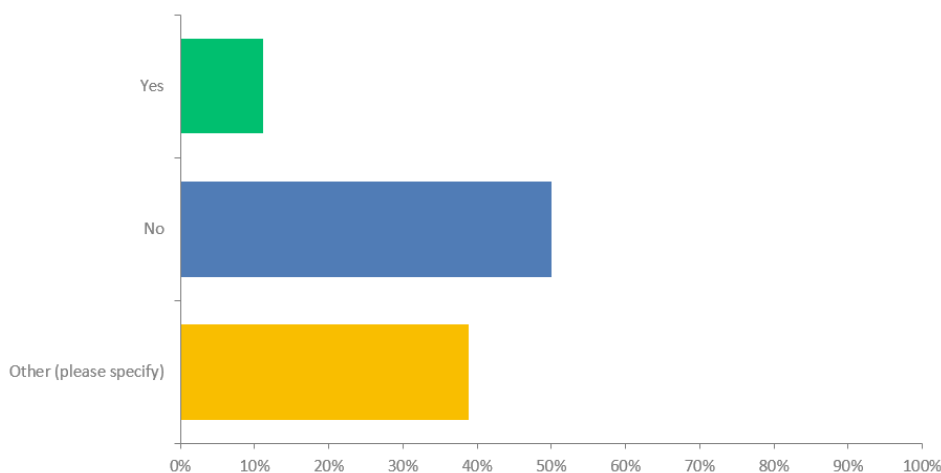
Answered: 14 Skipped: 4

# CLOSEST	# AVERAGE TIME SPENT	# FARTHEST	# AVERAGE TIME SPENT
1 Penn Highlands Dubois	1 1.87	1 Mount Nittany Medical Center	1 1.9
2 PENN HIGHLANDS DUBOIS	2 3-4 hours	2 ALTOONA HOSPITAL	2 3-4 hours
3 Critical care is not how a facility would be designated	3 5 hours - round trip	3 Penn Highlands Dubois	3 8 hours - round trip
4 Penn Highlands Dubois	4 1hr+	4 103 one way	4 75 minutes
5 70 one way	5 32.18 minutes	5 42	5 15
6 Dubois	6 20	6 45	6 2-3 hours
7 19.7	7 40 min	7 Penn Highlands Dubois	7 60 minutes
PM 8 15	8 3 hours	8 Penn Highlands Dubois	8 2.25 hours
9 Penn Highlands Elk	9 60 minutes	9 Penn Highlands Dubois	9 110 Minutes
10 65 miles	10 28 minutes	10 42 miles	10 3-3.5 hours
11 Penn Highlands Dubois	11 15	11 3 hours	
12 Penn Highlands Elk	12 1-1.5 hours		
13 1 mile			
14 1 hour			



When transporting an acute patient, does the ALS truck transport allowing the BLS to be back in service?

Answered: 18 Skipped: 0



Only 11% routinely allow ALS units to transport while returning BLS units to service. Most agencies do not use this model, limiting opportunities for resource optimization.

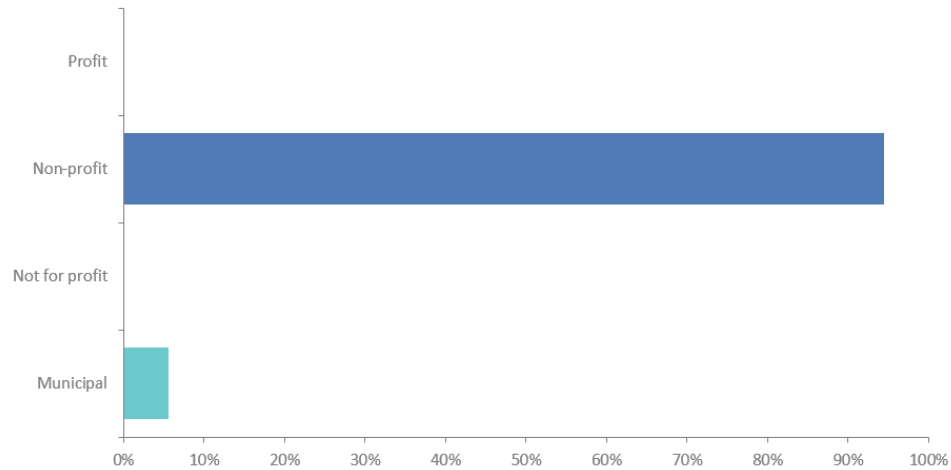
Other responses:

- Dual level staffed all units, so it typically doesn't apply.
- Our ALS service intercepts with our unit and their medics board our ambulances to continue transport.
- We are providing the ALS, and our paramedic would get on the BLS unit as they want to capture the transport.
- Our primary service run calls out of the same units.
- Sometimes
- Both primary responding trucks would be staffed at the ALS level. When doing Paramedic Assist to BLS agencies, the ALS provider responds with a crew of 1 to join the BLS crew.
- If a MICU is available, care is transferred to them for transport. If only a medic is available, transport is BLS with medic on board.



Is your agency?

Answered: 18 Skipped: 0





What is your agency's average cost of readiness per call?

Answered: 10 Skipped: 8

RESPONSES

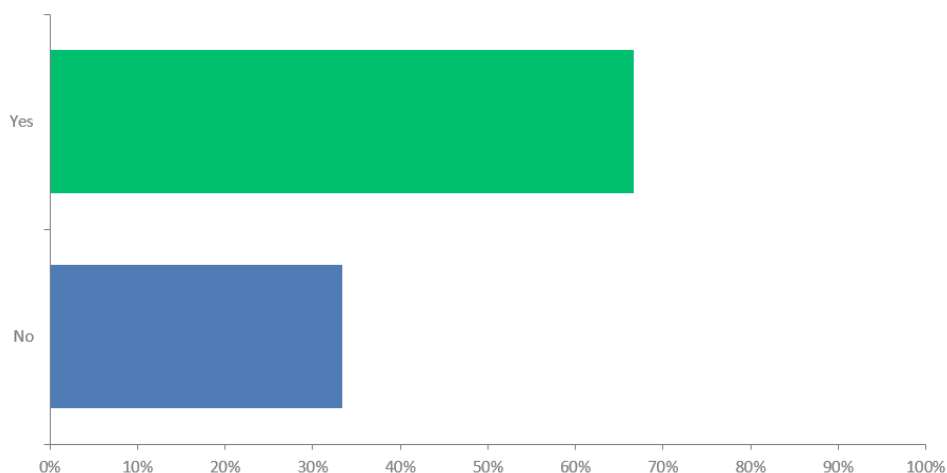
- 1 Budget divided by call volume equals approximately \$500.
- 2 \$360
- 3 \$100-\$200
- 4 \$500
- 5 69.44
- 6 \$475.00
- 7 775-800
- 8 This is a loaded question. What are we talking? Supplies? Truck? Equipment? Crew? Fuel?
- 9 \$114.51/hour
- 10 574.00

Agencies report widely varying budgets and readiness costs, with many relying on limited municipal support. Financial sustainability appears inconsistent and heavily dependent on external funding sources.



Does your agency receive support (financial/in-kind/insurance/etc.) from your municipal governments?

Answered: 18 Skipped: 0

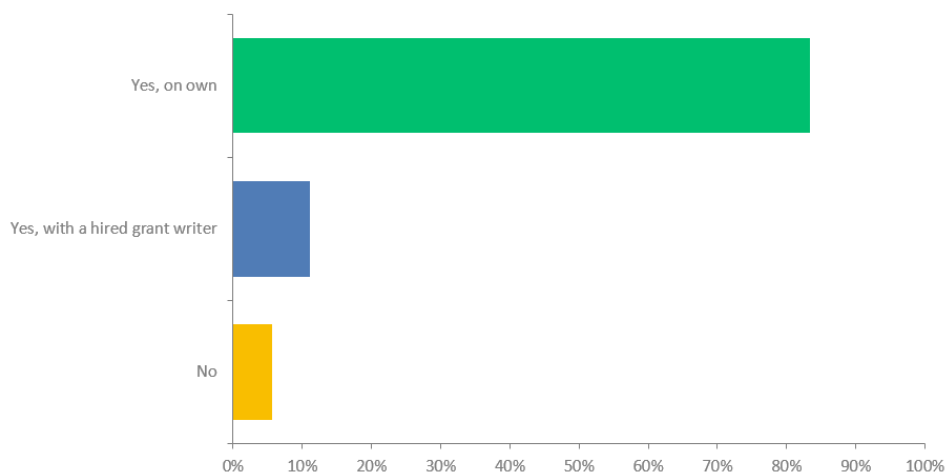


- Diesel Fuel for Ambulance
- Small Monetary Donation - Less than \$2000/yr
- Municipal Based that receive tax base money, contract for service agreement money, insurance reimbursement, and grants.
- Workers' compensation is paid for by our municipalities
- We have contracts with all municipalities with the exception of Ulysses Twp.
 - Huston Jay and Benezette provide financial assistance.
- We receive tax money from Ridgway Borough
- One Township provides funds based on responses – small amount less than 300.00
- We receive money from Emporium Borough yearly via Act 13 funding
- Tax millage
- Townships cover workers comp insurance premium
- Kane Borough - \$10,000



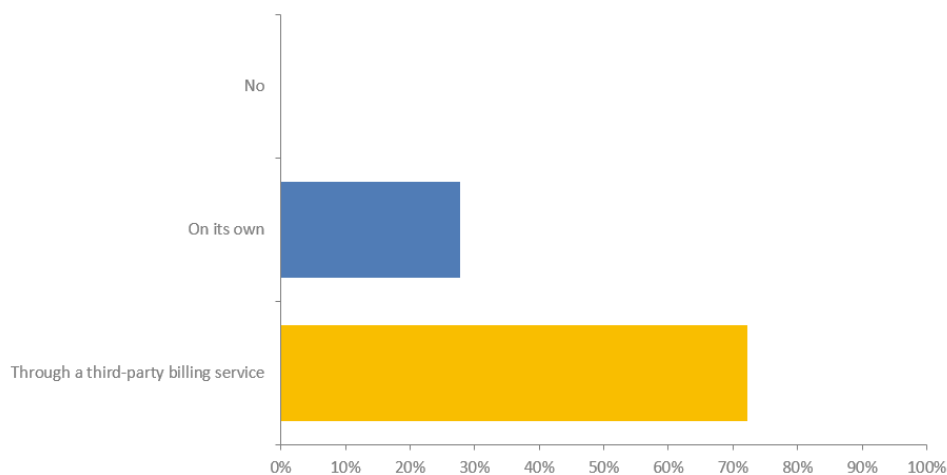
Does your agency utilize grants as part of your financial budget?

Answered: 18 Skipped: 0



Does your service bill for calls?

Answered: 18 Skipped: 0



Most agencies (72%) use third-party billing, with vendors retaining approximately 12% of collected revenue. While widely utilized, billing efficiency and collection rates remain variable.



If your service bills, what is the annual amount that is uncollected?

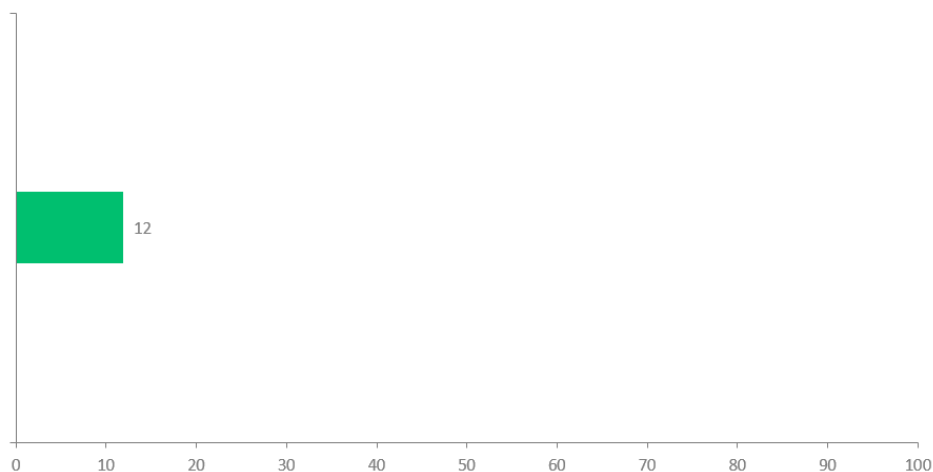
Answered: 11 Skipped: 7

RESPONSES

- 1 700,000
- 2 IT TAKES OVER A YEAR TO AT LEAST RECIEVE 50% OF SOME BILLINGS. WE DO HAVE A STACK OF UNCOLLECTED BILLS.
- 3 \$5,000
- 4 \$8-12,000
- 5 40000
- 6 \$100,000.00 approximately
- 7 335000
- 8 634,000
- 9 \$592,000
- 10 1,750,000
- 11 \$500-\$600

If your service bills through a third-party service, what percentage of funds does the vendor retain?

Answered: 10 Skipped: 8

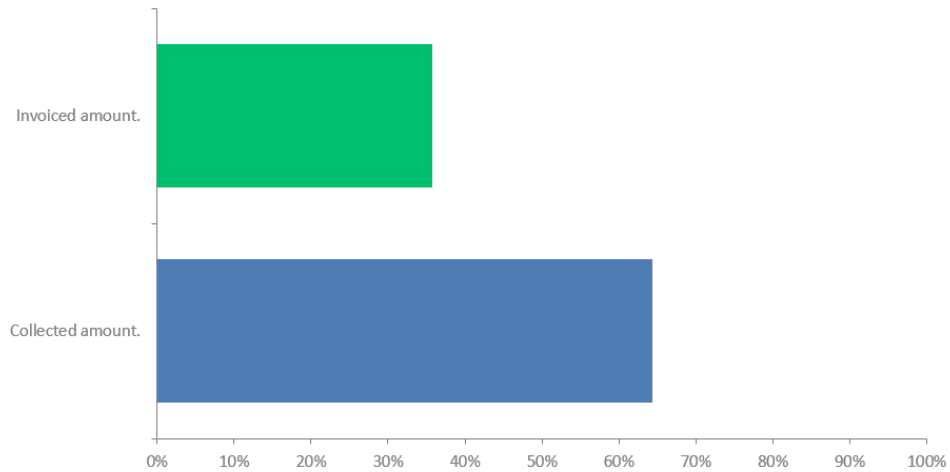


A collaborative billing agreement could be negotiated throughout the county or region to reduce the overall percentage retained by the vendor.



Does the billing vendor collect their fee based on the invoiced amount or the amount collected?

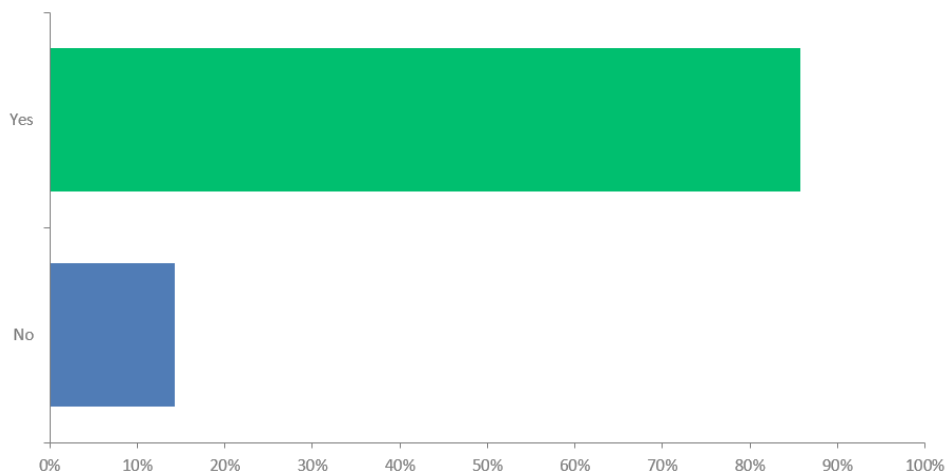
Answered: 14 Skipped: 4





Is your service satisfied with the billing service provided through a third party?

Answered: 14 Skipped: 4



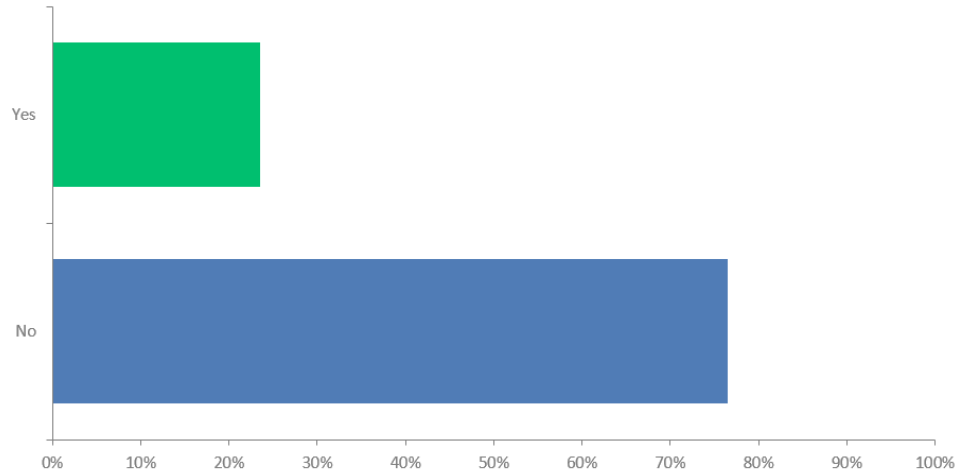
A majority of agencies (86%) are satisfied with their billing services, yet few are interested in collaborative billing models, instead accepting the current systems.

- We have seen a steady revenue stream. Communication of updates and billing issues or agency issues are handled, and monthly reports are all great things about our billing company.
- We pay them monthly whether we have calls or not.
- We use Cornerstone and they do a phenomenal job
- Wish they would push harder to collect
- They work well with our service
- 59, 60, and 61 do not apply to me, but as a service that offers third party billing, I can say we charge 8% on what is collected.
- It's not really cost effective for us due to volume of calls



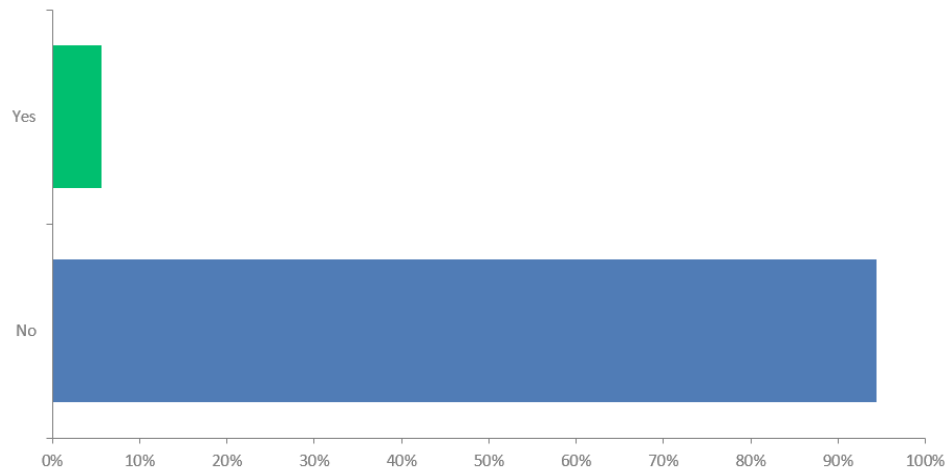
Would your service be interested in a "Collaborative Billing Solution" if it were available?

Answered: 17 Skipped: 1



Has your service ever participated in a busy study, a heat-map, or predicative call location study?

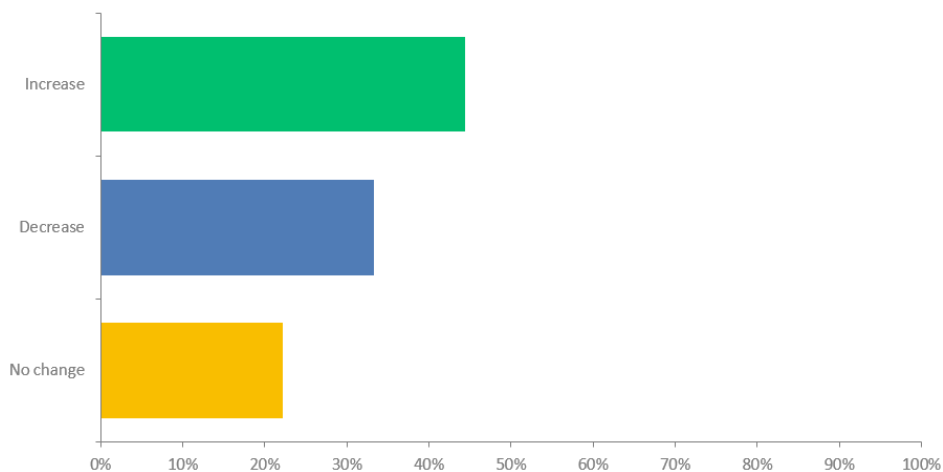
Answered: 18 Skipped: 0





Have you seen an increase or decrease over the last three years in the number of medical calls?

Answered: 18 Skipped: 0

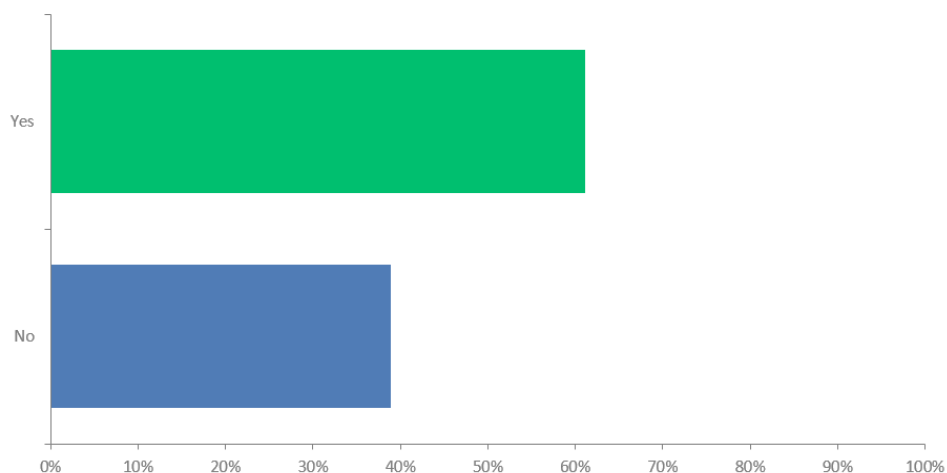


Responses are mixed, with 44% reporting increased call volume and 33% reporting decreases. This variability could suggest differing local trends rather than a uniform regional pattern, or the way in which agencies track calls for service.



Do you have a public education program in place? (First Aid/CPR/EMT/etc.)

Answered: 18 Skipped: 0



Most agencies (61%) offer public education, but only one-third coordinate with other public safety partners. Increasing collaboration could significantly enhance program effectiveness and broaden outreach potential.



What public education programs does your agency provide?

Answered: 11 Skipped: 7

RESPONSES

- 1 Community Based CPR Program in conjunction with an ETA, Water Safety to Preschool Kids
- 2 First Aid/CPR, ACLS, PALS, ITLS
- 3 Do not have these in the Kane area
- 4 First -Aid/CPR
- 5 First Aid and CPR programs
- 6 CPR First Aid/EMT training
- 7 CPR, Stop the Bleed, Babysitter course
- 8 first aid CPR / AED
- 9 First Aid, CPR/AED, Stop the Bleed, TECC, EMR, EMT, AEMT
- 10 First Aid/CPR/Stop the Bleed/Babysitter Certification
- 11 EMT, CPR

How often do you provide public education and to what audiences?

Answered: 11 Skipped: 7

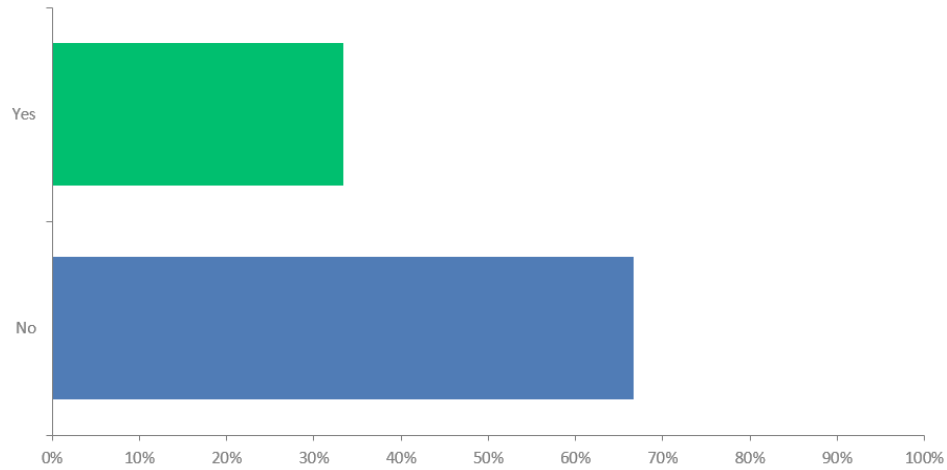
RESPONSES

- 1 CPR - 2x per year Water Rescue - 1x per year
- 2 2-3 times a month to a variety of audiences
- 3 WE HOST A MOCK DISASTER DRILL WITH OUR LOCAL FIRE COMPANY JUST FOR AWARENESS.
- 4 Quarterly - EMS and the public
- 5 Monthly trainings if needed and per request. Public and professional audiences.
- 6 As requested, or as registered
- 7 roughly 4 times a year
- 8 AS NEEDED, COMPANY EMPLOYEES
- 9 As schedule for Fire Aid/CPR/AED/Stop the Bleed/TECC/EMR EMT yearly AEMT yearly
- 10 1-2 times per month. All audiences within the community. Lay persons and medical professionals alike.
- 11 About once a month or every few months. We go to job fairs, touch a truck events and public outings.



Do you coordinate your public education sessions with any other public safety groups?

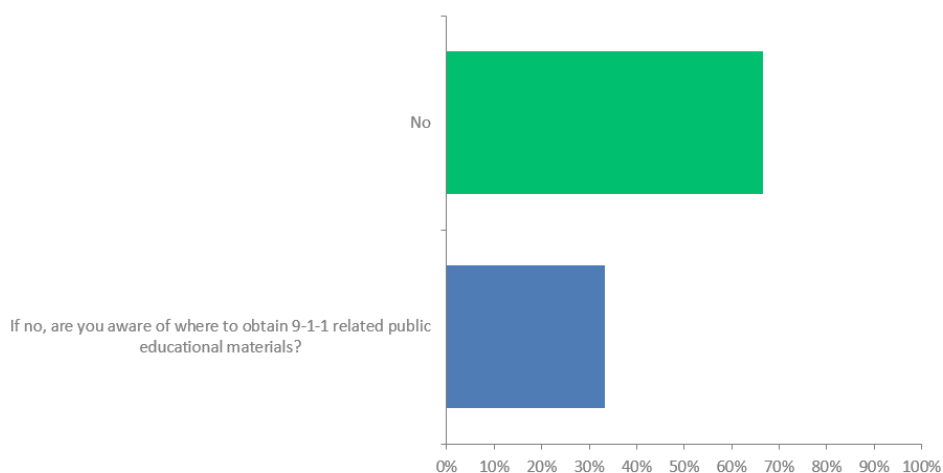
Answered: 15 Skipped: 3





Does your public education material include when to call 9-1-1 and what constitutes an emergency?

Answered: 6 Skipped: 12

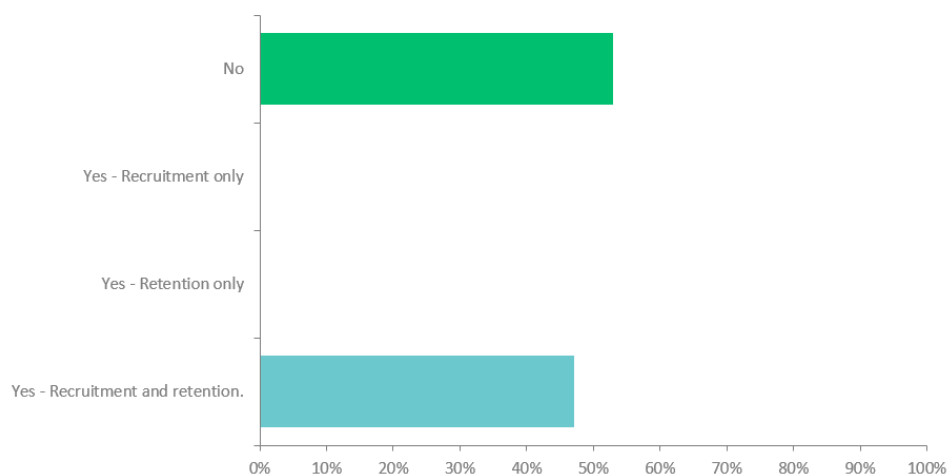


While some agencies engage in public education, few explicitly incorporate guidance on when it is appropriate to call 911. This gap represents a meaningful opportunity to shape system demand through more targeted and intentional messaging. Through increased communication, and repeated, consistent messaging, what constitutes an emergency and a need to dial 911, demand on EMS for services that do not require an emergency response should decrease, allowing the EMS resource to remain available for emergencies.



Do you have recruitment/retention programs in your agency?

Answered: 17 Skipped: 1



Volunteerism is in decline across the nation and the median age of existing volunteers continues rising. Individuals who once volunteered significant time to an agency are aging, while would be volunteers time is consumed by increasing personal and work commitments, leaving little time commitment availability. Over half of agencies who responded lack of formal recruitment or retention programs, and workforce turnover remains steady with limited new entrants. Staffing shortages are consistently identified as a critical issue.



If recruitment/retention of staff is an issue for your agency, please explain.

Answered: 13 Skipped: 5

RESPONSES

- 1 We do not have a formal recruitment/retention program. We do have several members that actively talk with community members about our team and how we integrate into the community. We have tried utilizing social media and other avenues for recruitment with a lower success rate than face to face interactions.
- 2 Recruitment in general of trained personnel has been challenging
- 3 WE FEEL IT'S A GLOBAL ISSUE, NOT JUST A LOCAL ISSUES, ALTHOUGH OUR POPULATION IN TOWN IS MOSTLY ELDERLY AND NOT INTERESTED IN VOLUNTEERING.
- 4 We have given gear bags, keychains, and t-shirts to our staff. However, everyone works full time jobs and it's hard to have 24-7 coverage.
- 5 We offer recruitment and retention for our members. However, it is still very hard to get the younger people involved and want to volunteer.
- 6 We can't afford to pay hourly EMTs enough for what it is. Most people on our roster work other full-time jobs and cover as needed. lack of interest and good candidates.
- 7 Yes, we need help with recruitment, we have no help whatsoever
- 8 Recruitment and retention are intertwined issues. If we cannot staff units and handle emergent and non-emergent activity that is billable, we cannot get funds into the service to be competitive in wages, benefits for staff, and replacement of equipment that is used.
- 9 It can be challenging to retain staff. EMS is one of the most underpaid professions and that is due to the reimbursement rates.
- 10 WE ARE A RURAL ORGANIZATION THAT WHERE MOST AVAILABLE PETRSONS WORK OUT OF TOWN AND NOT AVAILABLE THOSE TIMES
- 11 Trying to find new volunteers and employees is extremely difficult. No one is beating down the door. We did do retention programs during COVID with grant money, but not more people stayed vs left during that time.
- 12 No workforce available to recruit. Limited funds to provide retention efforts
- 13 This is an issue due to the ruralness of the area and lack of people from which to recruit. This is why we have only one active EMT. We do participate in meetings, round tables and other educational opportunities that focus on recruitment and retention - we just simply do not have a population base.

What is your agency's turnover rate?

Answered: 15 Skipped: 3

HOW MANY NEW VOLUNTEERS/EMPLOYEES ARE ONBOARDED ON AVERAGE PER YEAR?

- | | |
|----|-----|
| 1 | 2 |
| 2 | 1 |
| 3 | 1 |
| 4 | 1 |
| 5 | 1-2 |
| 6 | 3 |
| 7 | 1-2 |
| 8 | 1 |
| 9 | 4-5 |
| 10 | 3 |
| 11 | 0 |
| 12 | 2 |
| 13 | 3-4 |
| 14 | 4 |
| 15 | 0 |

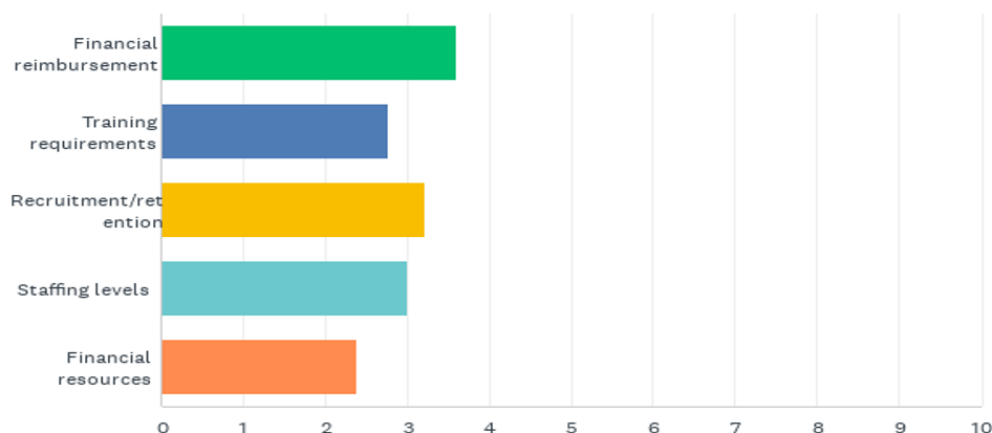
HOW MANY VOLUNTEERS/EMPLOYEES ARE LOST ON AVERAGE PER YEAR?

- | | |
|----|-----|
| 1 | 2 |
| 2 | 1 |
| 3 | 1 |
| 4 | 2 |
| 5 | 3 |
| 6 | 1-2 |
| 7 | 1 |
| 8 | 2-3 |
| 9 | 3 |
| 10 | 0 |
| 11 | 2 |
| 12 | 3-4 |
| 13 | 4 |
| 14 | 0 |



Please rank the following issues in order of what you feel is the most significant issue facing EMS response in your area currently. (Please click on the up/down arrows to move selections with your most significant at the top.)

Answered: 18 Skipped: 0



Respondents identify recruitment, funding, training barriers, and reimbursement limitations as the most pressing challenges. Many highlight the unsustainability of volunteer models and insufficient reimbursement rates.

Please rank the following issues in order of what you feel is the most significant issue facing EMS response in your area currently. (Please click on the up/down arrows to move selections with your most significant at the top.)

Answered: 18 Skipped: 0

	1	2	3	4	5	TOTAL	SCORE
Financial reimbursement	33.33% 6	27.78% 5	11.11% 2	22.22% 4	5.56% 1	18	3.61
Training requirements	11.11% 2	16.67% 3	22.22% 4	38.89% 7	11.11% 2	18	2.78
Recruitment/retention	27.78% 5	22.22% 4	11.11% 2	22.22% 4	16.67% 3	18	3.22
Staffing levels	22.22% 4	5.56% 1	44.44% 8	5.56% 1	22.22% 4	18	3.00
Financial resources	5.56% 1	27.78% 5	11.11% 2	11.11% 2	44.44% 8	18	2.39



If there are other issues that are of significant issue facing EMS response, please elaborate.

Answered: 6 Skipped: 12

RESPONSES

1 Recruitment/retention far surpass any other issue facing our service. As a volunteer service we do not find ourselves having financial constraints resulting from wages/benefits that could limit our ability to provide the service. In the event paid staffing would be required, there would have to be an investment made by the municipalities we serve to support that initiative.

2 Testing becoming too hard for some. Population aging and not enough young people in the area willing to go through the 160 hours of training. The cost of some classes is slightly on the expensive side for some and getting the reimbursement process going is difficult. Volunteering is especially hurting right now because of the economy and how a lot of people, even our dedicated staff, cannot afford to volunteer due to needing to work more and longer hours to support themselves and families. We've paid for several people to take classes with the hopes that they'd continue running with our service and as soon as they obtain their certificates, they leave to go get paid in EMS instead of volunteering with our service. We've lost out on lots of money doing that for several people who either never finished the courses or left to get paid.

3 This is strictly a volunteer service. The call volume isn't enough to make it a paid service and people have to work full time jobs to make a living. The others in the area are retired and can't get around to help. Therefore, our area suffers from lack of emergency medical services.

4 Aging equipment and being able to afford replacing it.

5 Recognition and being understood that we are part of the public service realm.

6 Staffing vs call volume vs training ALS resources Proper dispatching of calls



Based on your ranking of the most significant issues facing EMS service in your area currently, do you have any ideas on how to improve the current situation?

Answered: 13 Skipped: 5

RESPONSES

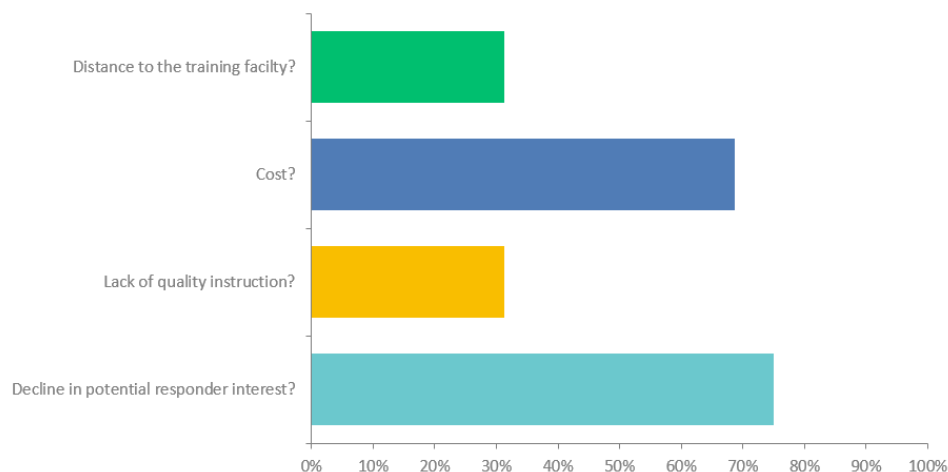
- 1 I do not. Though I sometimes feel like we as a service are not doing enough to reach out to community members to ensure they know and understand our current staffing limits, we can only do so much to create a "buzz" to get people interested. DATE
- 2 Need to provide funding to compensate personnel for operating ems services. Funding or resources to supplement operational costs, such as equipment and apparatus.
- 3 To make the classes more affordable, even with reimbursement programs it still requires people to pay upfront to be reimbursed and some people cannot afford to put the money down upfront. Recruitment and retention has long been an issue in the country, but it especially hits the volunteer service harder as less people are unwilling to volunteer or cannot afford to volunteer their time due to the economy and needing to work or take care of their families.
- 4 The system needs to be financially supported from a community need model rather than just want we can afford through reimbursement model.
- 5 No
- 6 We have the same individuals who are responding to call after call. They burn out. It would be nice to be able to offer our volunteers something in return for all the time they spend helping others. In this day and age with the cost of fuel something should be able to be given to volunteers to help with that.
- 7 Good people and being able to pay them enough
- 8 A multifaceted approach of legislation, establishing fee schedules and elevating from a Bureau to commissioner level that reports directly to the governor.
- 9 We need to get the reimbursement rate increased. I also think the cost of the certifications for EMS is too expensive for the pay that is received.
- 10 Honestly no
- 11 I think too many service over-pay their employees at times to retain and recruit them to a service; when that service can't afford that fee schedule in the end. This steals employees and volunteers and kills services in the long run. Services do not need to be billing \$1,500 per BLS call when Medicare only reimburses a third of that. Services should be more mindful of their area (populations, income, etc.) and bill based on what they can afford and then staff accordingly. Yes, I would love more money to do my job, and I would love to pay my employees more money, but we can only do so much and to remain in business pay what we can afford and find alternatives to keep employees on the job.
- 12 Increase insurance provider reimbursements for EMS services. Lobby federal legislation on CMS Ambulance Fee Schedule rates which are significantly insufficient. Increase revenue for EMS=greater wage increases for providers and ability to provide a competitive livable wage as compared to a comparable medical professional=greater recruitment and retention of workforce.
- 13 No. Have been meeting with local officials, neighboring agencies and other legislative and DOH folks on issue.

A majority of responses directly or indirectly point to financial instability as the root issue include Medicare and Medicaid reimbursement rates, insufficient revenue to continue operations, and the need to reform legislation. Recruitment and retention are frequently identified concerns, particularly attracting new individuals and replacing those leaving the services.



EMS training requirements have been ranked near the top as one of the most significant issues faced by agencies across the nation. In your opinion is this issue due to [Select all that apply]:

Answered: 16 Skipped: 2

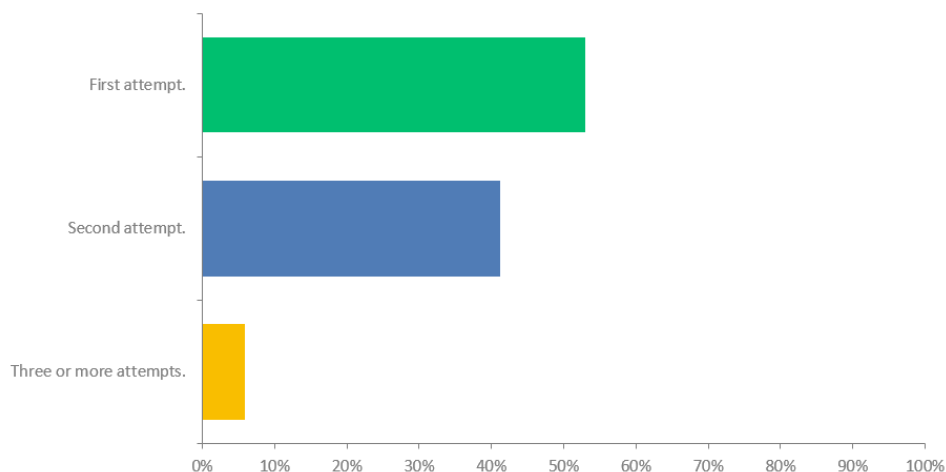


Training challenges are largely attributed to cost (69%) and declining interest (75%), with moderate first-attempt pass rates (53%). Concerns from many of the agencies surround the unwillingness of candidates to re-take the course and/or test if they do not succeed on the first attempt. These barriers contribute directly to workforce shortages.



What is the pass rate on EMS training within your agency?

Answered: 17 Skipped: 1



If the pass attempt rate is two or more, what contributes to the multiple attempts required, if know?

Answered: 7 Skipped: 11

RESPONSES

- 1 Not dedicating time to studying outside of class. Not asking instructors for remedial training when they are struggling.
- 2 Test was too challenging for most
- 3 This depends on who the class is taught through. EMT class taught through Penn College has a first attempt pass rate. We still have a member who has taken the class through NPRC that has not been able to pass after the third attempt.
- 4 The student needs to take advantage of more training opportunity other than the scheduled class. Our staff make themselves open to additional training opportunities for students.
- 5 not familiar with test taking on computer and questions from National Registry not being as for testing protocol in Pennsylvania.
- 6 Lack of interest and time spent preparing.
- 7 NA - we can't get anyone interested in taking a course.



In what areas do you need assistance from municipal or county government?

Answered: 15 Skipped: 3

RESPONSES

- 1 It is important for municipal government to be involved with Emergency Services in their community. They need to be up to date with staffing, finances and future goals. If the leadership of the community doesn't have a vested interest in the services within, then the citizens most likely won't either.
- 2 Operational costs. Staffing is a must and can be maintained and managed. The costs associated are rising and unmanageable.
- 3 Funding for a readiness model
- 4 We need assistance with recruitment and retainment. Possibly not having to pay property taxes like other volunteer fire departments in larger areas and states have. This would help substantially. Or even free or low-cost healthcare. That would help too.
- 5 We are very lucky that our municipalities work with us. On the County Government it would be nice to see if they set something to help volunteer members who are active and responding to calls with their taxes or in another form.
- 6 Financial assistance to pay better for recruitment and retention and be able to replace aging equipment
- 7 Help with recruitment and training reimbursement
- 8 There is always going to be a financial need due to low medical reimbursements. 9 Funding so that we can attract staff and give them a livable wage. Also partnering with standalone services and seeing what other opportunities that opens up for funding, training, or reduction of cost to operate the service.
- 10 Funding for equipment and units
- 11 We would like them to recognize if they don't get involved there would be longer wait times for ambulance service due to outside ambulances having to cover a larger cover area because of the lack of personnel available locally.
- 12 I hate to say we need an EMS tax, but the way the world is going, I can see in the future, maybe within 10 years, we are going to need a EMS tax to survive.
- 13 Lobbying for increase in insurance reimbursements for EMS. Financial assistance for operational costs and funding for capital improvement projects such as facility renovations and equipment purchases/replacements
- 14 Financial help
- 15 Establishing an EMS/Fire tax to build a pot of money to be able to support a "regionalized" approach to cover area when current ambulance is no longer able to respond.

Agencies consistently referenced the need for additional financial support, workforce incentives, and policy changes such as improved reimbursement rates. Additional comments emphasize more systemic challenges, including hospital relationships, transport dynamics, and long-term sustainability concerns.



Are there any other comments or information you would like to provide?

Answered: 6 Skipped: 12

RESPONSES

5 All information in this survey was answered with data from the year 2025; unless asked in a question. One area that was not covered in this survey but becoming a huge issue is covering other services calls. Pulling our units out of our coverage area for longer and longer periods of times. There is not good solution for this yet in PA. It cost services money to do with not real reimbursement. We plan and schedule our crews for our area and yet at times our plan fails due to covering other areas. Second, in 2025 we had a big funding boost from our local hospital system by the means of non-emergency transport. By the hospital using local EMS to support transfer of patient, we were able to increase staffing, increase payroll per hour, and replace necessary equipment without a problem. This increased our call volume by 1,000 calls last year and increased our budget income by almost \$500,000. It created a sense of financial freedom and reduce a lot of the worry most ambulance service face. On the flip side, this created 1,000 more calls for our service, a lot more stress, and work. Was there still patient not getting move because there were more transports needed then ambulance available...yes. What really hurts, is that the local hospital now outsource all of these transport to a out of the area third party ambulance service with no ties to local EMS or local funding. Sending this money outside our local county area. We have had to cut shifts off our schedule, not longer can schedule addition crews. This not only hurts our service, but the smaller service we cover for turnovers and out of service services. Basically, creating less service available in our area by using the third-party vendor. Other hospital system (AHN/UPMC) do it different and try to use local before using a third-party vendor. This has created a monopoly on transport, taken away critical funding for local EMS, and delayed discharged and transfer from the hospital. This then causing the hospital to hold more and more patient longer, possible delaying EMS turn around times in the ER due to patient overload. Third, hospital system in the area in general. They is a shortage of not only EMT/Paramedics, but nurses in general. Having more nurses in general in the hospital on the floors, ER, ICU, etc. would, in my opinion, help the EMS system in general. Take some of the strain off of EMS. Weather it is turn around times, transporting patient to other hospital, or facility transport in general. More nurses would be great. There is a lack of training in this area. More and more colleges are closing campuses. To become a nurse or paramedic is getting harder and harder. I find myself referring more and more people to become nurses then paramedic. Nurses can do the job of a paramedic, but not the other way around. There is not advancement in EMS. Yes, you can become a supervisor or director. Go from EMT to Paramedic but not like you can with being a nurse. Types of nursing; additional education, 3/13/2026 12:57 PM 1 / 2 Workforce Solutions NC, PA EMS study - EMS Services leadership, you name it; can be done by nurses but not paramedic in PA. Other state have more opportunities for paramedic, that PA just doesn't have. More skill sets, better pay, Community Paramedicine just to name a few. Things that aren't offered in our state. Things that will take forever to be possible in our state. It up to the services to offer these programs and to find ways to pay for them along the way. It not a billable thing in PA either. We are very limited on the way we can bill and get paid. It not always far, everyone bills differently, but at the end of the day we all get paid the same. Start up and millage. You can bill 1 million dollars, but you're only reporting more loses then your neighbor. You and your neighbor make the same amount of money in the end. Medicare runs the show, followed by State laws. I did not upload documents to this survey. I do not believe some reports were legally be able to be uploaded to this survey. I would love to share the information data as best I can in person or answer addition question. Some of the question in this survey were difficult to understand and answer and some question that should have been ask I felt were left out. Thank you for taking the time to put this survey together and I look forward to speaking more in depth about some of these issues.

6 Our main issue is staffing - recruiting new folks. We are one EMT away from closing our doors.

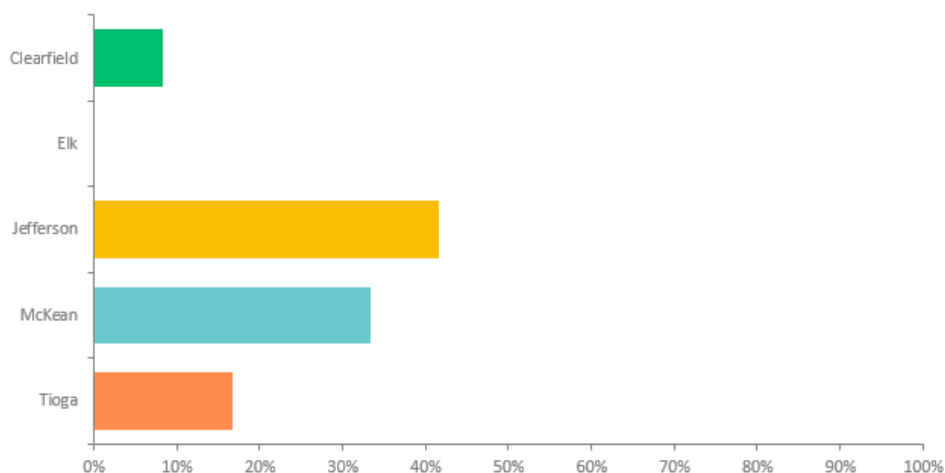


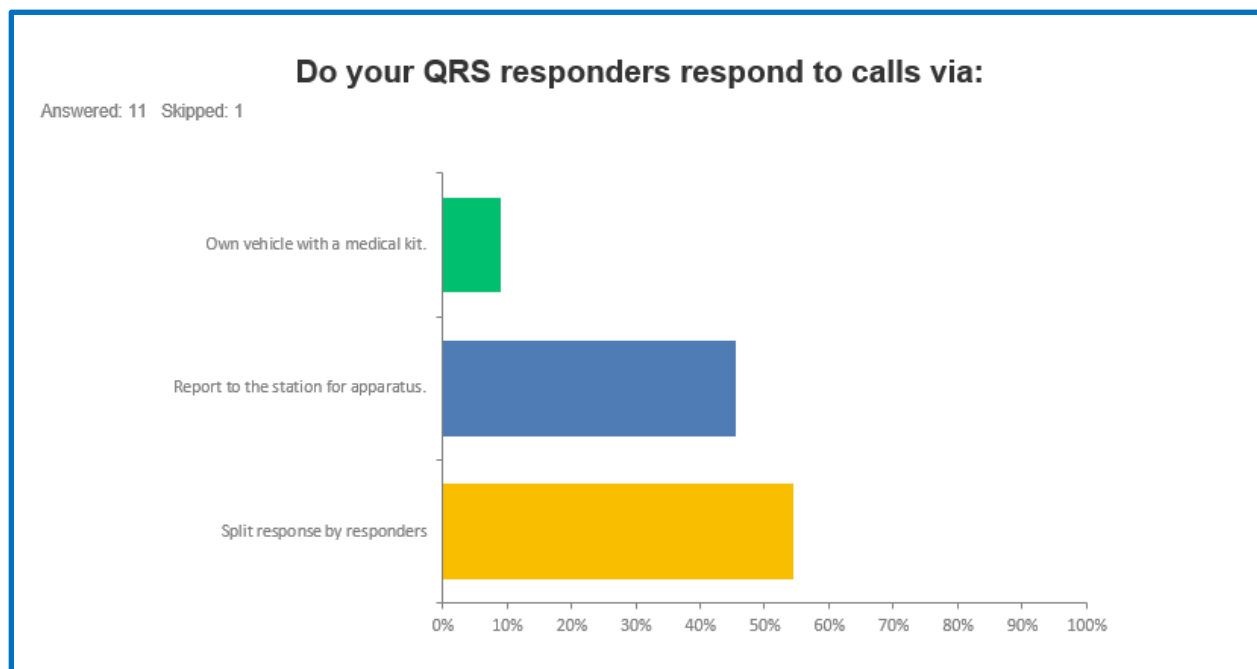
QRS Services

Workforce Solutions NC, PA EMS study - QRS Services

Which 911 center/PSAP dispatches your fire services' QRS?

Answered: 12 Skipped: 0





Most agencies utilize either a split response model (54.5%) or station-based response (45.5%), with personal vehicle (POV) response used only minimally. This distribution is consistent with quick response service (QRS) agencies that often rely on hybrid response approaches. In rural environments in particular, it is common for personnel to respond both to the station, ensuring apparatus are staffed and able to transport necessary equipment, and directly to the scene, where nearby responders can initiate patient care prior to the arrival of the primary response unit.



Please indicate how many of your members participate and to what level they are cross-trained. (Please include the number of members for each selection.)

Answered: 12 Skipped: 0

# CPR ONLY	# EMSVO (EMS VEHICLE OPERATOR)	# EMR (EMERGENCY MEDICAL RESPONDER)	# EMT	# A-EMT	# EMT-P (PARAMEDIC)
1 18	1 6	1 7	1 8	1 0	1 0
2 8	2 10	2 0	2 2	2 0	2 2
3 12	3 4	3 1	3 4	3 1	3 0
4 10	4 13	4 3	4 2	4 0	4 1
5 17	5 5	5 0	5 12	5 0	5 0
6 20	6 0	6 3	6 1		6 0
7 15	7 12	7 2	7 0		7 0
8 11	8 26	8 1	8 8		8 2
9 24	9 13	9 2	9 14		9 1
10 18	10 10		10 10		
11 12			11 12		
			12 4		

Agencies have significant CPR-level personnel but far fewer EMR, EMT, and almost no advanced providers.

Please indicate how many of your members participate and to what level they are cross-trained. (Please include the number of members for each selection.) Continued

Answered: 12 Skipped: 0

# PHRN (PREHOSPITAL REGISTERED NURSE)	# PHPE (PREHOSPITAL PHYSICIAN EXTENDER)	# PHP (PREHOSPITAL EMS PHYSICIAN)
1 0		
2 1	0	0
3 0		
4 0		
5 0		
6 0		



Of those that are cross trained medically, how many have a National Registry Certification?

Answered: 9 Skipped: 3

RESPONSES

1	2
2	0
3	3
4	3
5	0
6	2
7	5
8	5
9	2

If you answered the question above, please include the levels of National Registry certification. (Please provide a 1 levels).

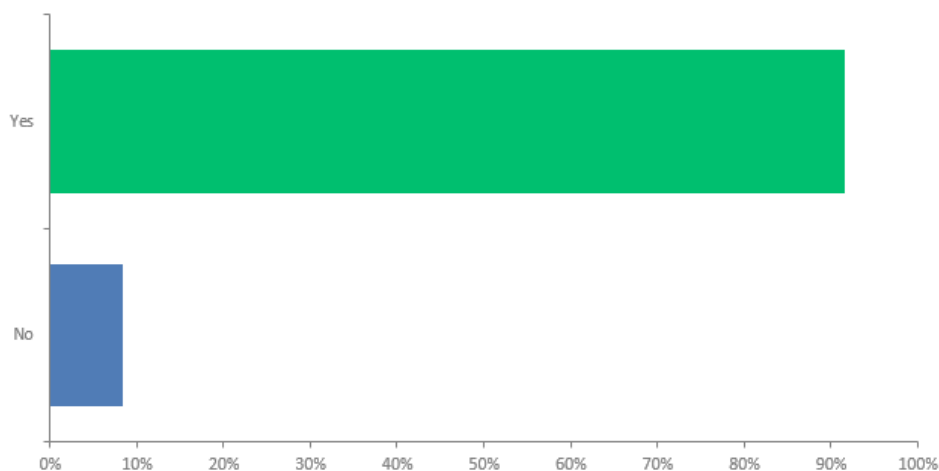
Answered: 5 Skipped: 7

#	RESPONSES
1	EMT-B, EMT-P
2	EMT-B
3	EMT-B
4	NEMT
5	1 NRP 1 EMT



Does your organization arrive on scene of a QRS call prior to the ambulance?

Answered: 12 Skipped: 0

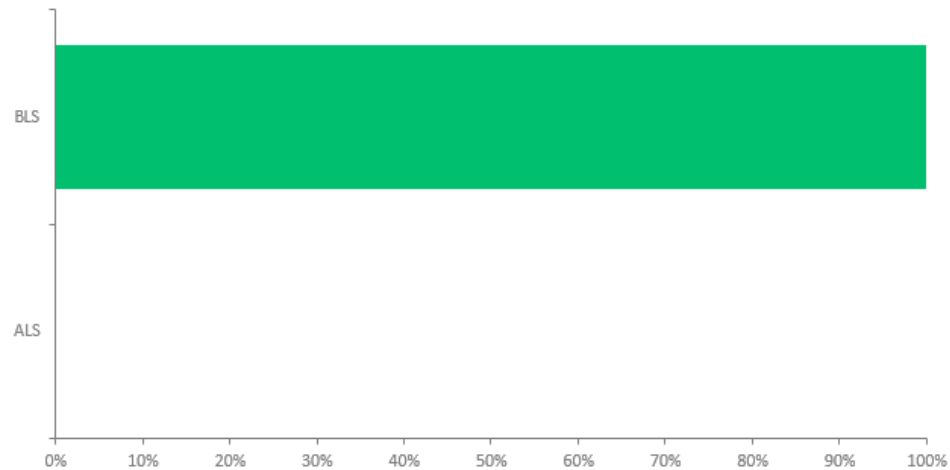


Over 91% of respondents report arriving before the ambulance. This confirms that QRS services are critical gap-fillers, effectively acting as the first point of care in most incidents across a rural setting.



What service is your agency licensed to provide?

Answered: 11 Skipped: 1



How many of your agency's vehicles are licensed as QRS apparatus?

Answered: 12 Skipped: 0

#	BLS	#	ALS
1	1	1	0
2	2	2	0
3	1	3	0
4	2	4	0
5	1	5	0
6	0		
7	0		
8	1		
9	3		
10	2		
11	1		
12	1		



How many of your QRS personnel work/volunteer at:

Answered: 12 Skipped: 0

MULTIPLE EMS AGENCIES

1	1
2	0
3	7
4	0
5	0
6	0
7	0
8	2
9	4
10	2
11	4
12	3

OTHER FORMS OF PUBLIC SAFETY AFFILIATIONS

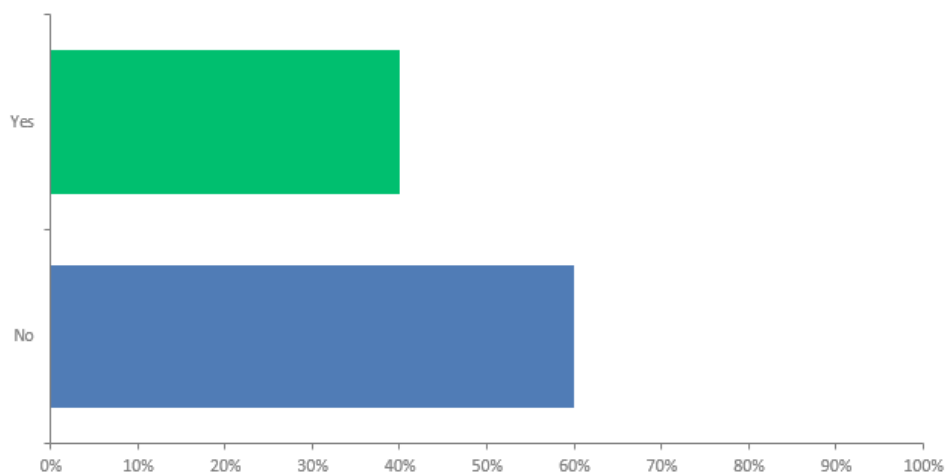
1	1
2	0
3	1
4	0
5	0
6	0
7	2

Many personnel also serve in other EMS functions or other public safety roles, which is reflective of a shared labor pool. Serving in multiple capacities tends to increase the demand on individuals which, in turn, increases the risk of burnout and availability conflicts.



Are employers supportive of volunteers leaving work to report to QRS calls?

Answered: 10 Skipped: 2

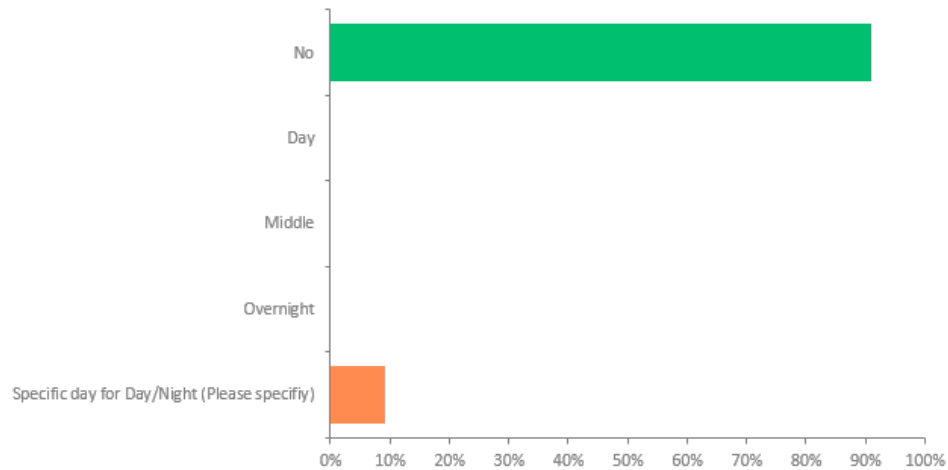


Employer policies that restrict employees from leaving work to respond to EMS calls limit the available responder pool, particularly in volunteer and combination systems. This results in fewer personnel available during daytime hours, often leading to delayed responses or increased reliance on mutual aid. As a result, response times can become inconsistent, and the burden shifts to a smaller group of available responders, increasing fatigue and burnout. Over time, these restrictions further weaken system reliability and strain already limited staffing resources.



Does your service schedule QRS crews?

Answered: 11 Skipped: 1

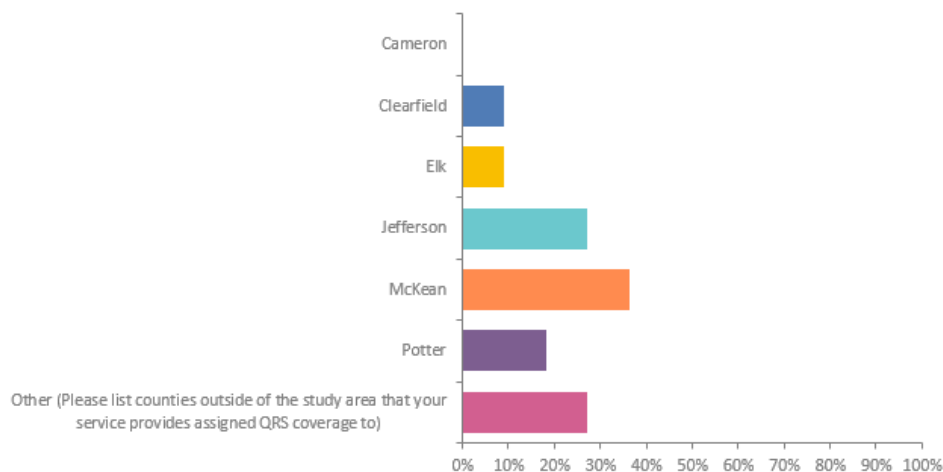


An overwhelming majority of the respondents do not schedule QRS crews, instead relying on the availability of members, leading to an unpredictable coverage model.



List the counties to which your service provides assigned QRS coverage. (Select all that apply)

Answered: 11 Skipped: 1



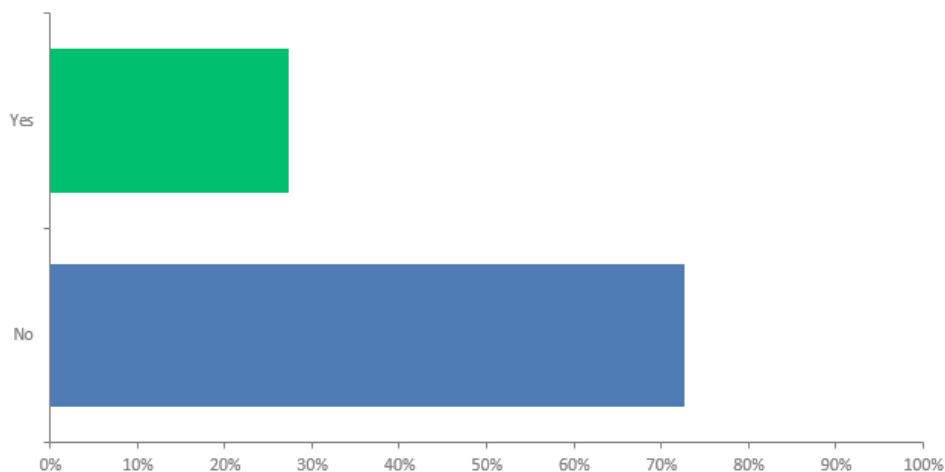
Other responses:

- McCalmont Twp, Bell Twp & Young Twp and by special request Jefferson County
- Corydon Twp (part of) McKean
- Corsica Boro, union, clarion, limestone, and Millcreek townships
- Corydon Twp , McKean
- Elk Twp, Warren
- Foster Township
- Warsaw Twp Jefferson County
- Polk township Jefferson County
- Horton Township/ Elk County
- Bradford Twp
- Part of Foster Twp
- Both in McKean County
- Lawrence Township and Clearfield Borough
- Coudersport Boro, Eulalia, Sweden ,Homer, Hebron Twps, 1/3 Of Allegany and 1/2 of Summit Twp.
- Abbott, Elk, West branch



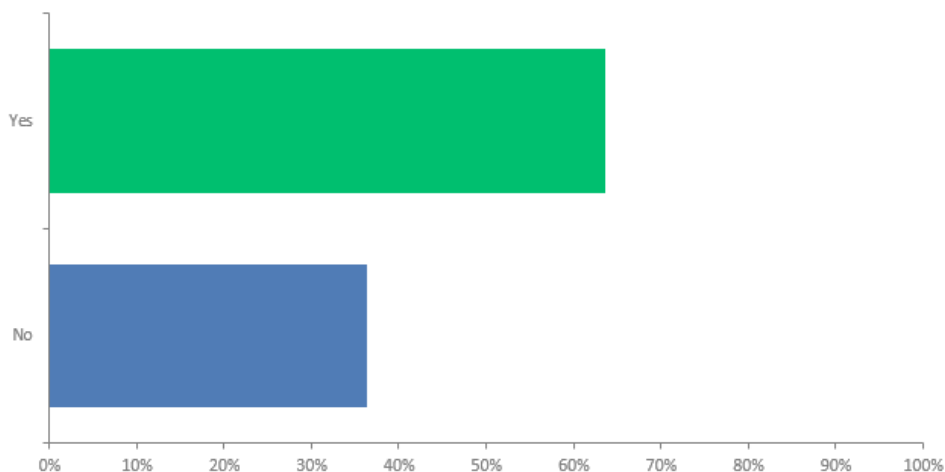
Does your service provide QRS coverage outside your service area?

Answered: 11 Skipped: 1



Is your service ever dispatched to cover QRS calls for other services?

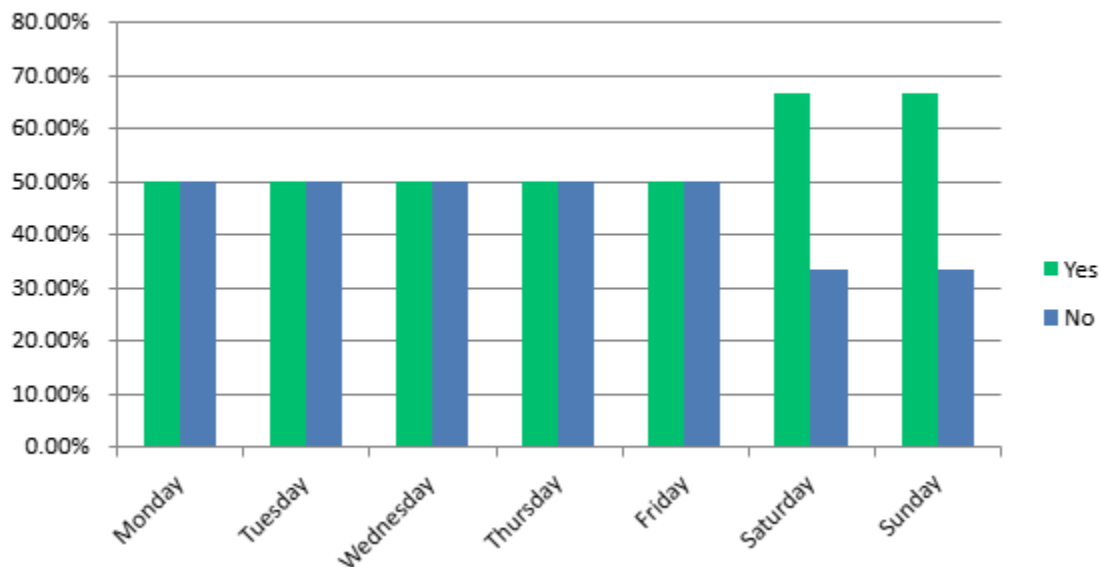
Answered: 11 Skipped: 1



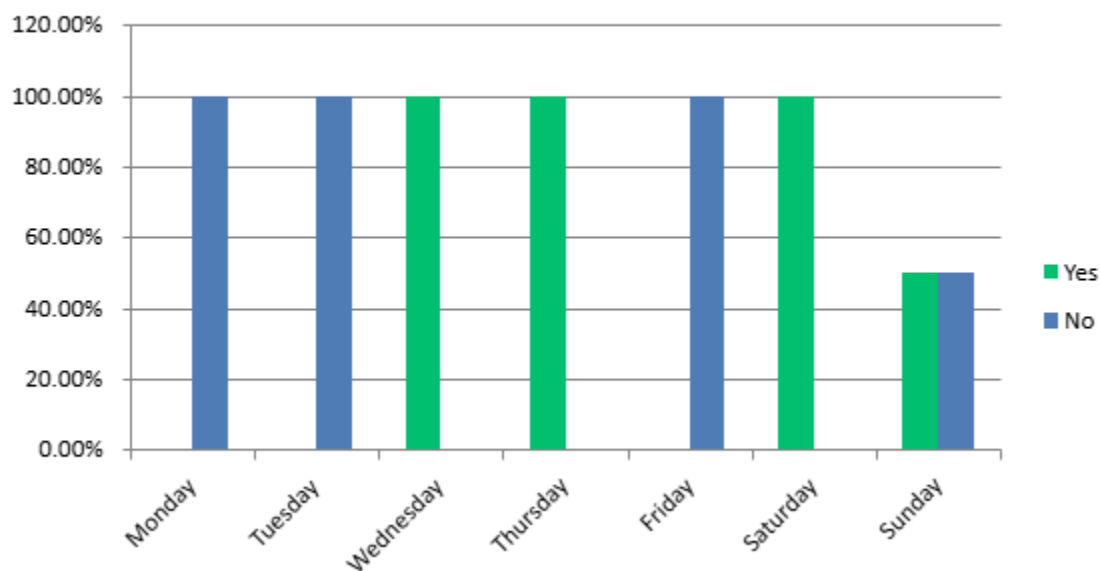
A large number of respondent agencies are dispatched to cover other services, further illustrating the frequent strain to backfill a response.

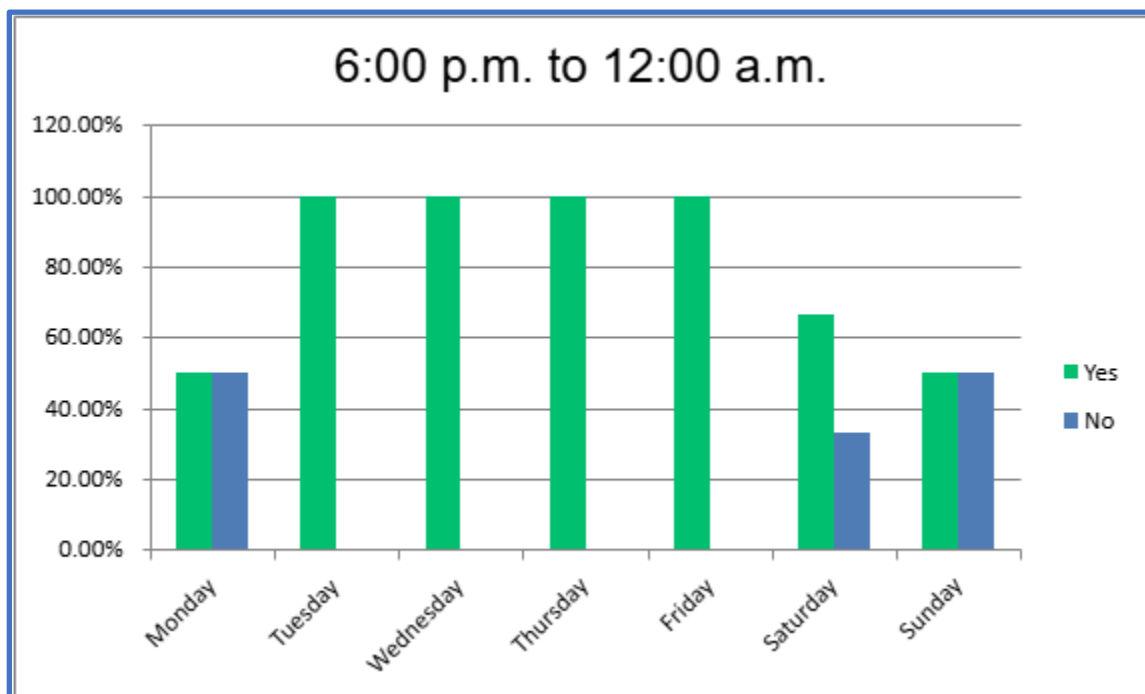
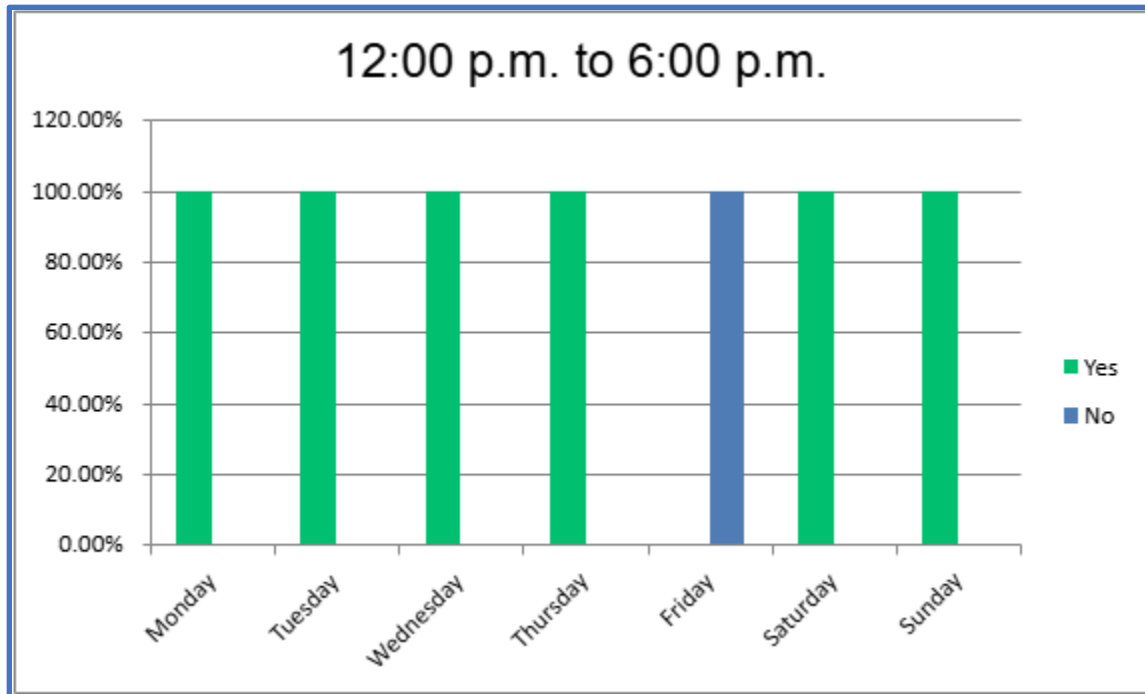


12:00 a.m. to 6:00 a.m.



6:00 a.m. to 12:00 p.m.







What are the busiest days/times of the week for your fire service regarding QRS calls?

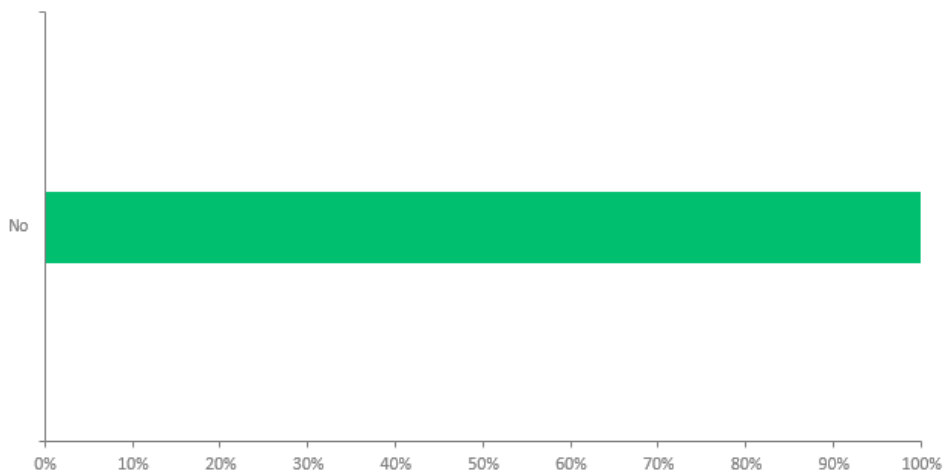
Answered: 3 Skipped: 9

12:00 a.m. to 6:00 a.m.				
	YES		NO	TOTAL
Monday	50.00%	1	50.00%	2
Tuesday	50.00%	1	50.00%	2
Wednesday	50.00%	1	50.00%	2
Thursday	50.00%	1	50.00%	2
Friday	50.00%	1	50.00%	2
Saturday	66.67%	2	33.33%	3
Sunday	66.67%	2	33.33%	3
6:00 a.m. to 12:00 p.m.				
	YES		NO	TOTAL
Monday	0.00%	0	100.00%	1
Tuesday	0.00%	0	100.00%	1
Wednesday	100.00%	1	0.00%	1
Thursday	100.00%	1	0.00%	1
Friday	0.00%	0	100.00%	1
Saturday	100.00%	2	0.00%	2
Sunday	50.00%	1	50.00%	2
12:00 p.m. to 6:00 p.m.				
	YES		NO	TOTAL
Monday	100.00%	1	0.00%	1
Tuesday	100.00%	1	0.00%	1
Wednesday	100.00%	1	0.00%	1
Thursday	100.00%	1	0.00%	1
Friday	0.00%	0	100.00%	1
Saturday	100.00%	2	0.00%	2
Sunday	100.00%	1	0.00%	1
6:00 p.m. to 12:00 a.m.				
	YES		NO	TOTAL
Monday	50.00%	1	50.00%	2
Tuesday	100.00%	2	0.00%	2
Wednesday	100.00%	2	0.00%	2
Thursday	100.00%	2	0.00%	2
Friday	100.00%	3	0.00%	3
Saturday	66.67%	2	33.33%	3
Sunday	50.00%	1	50.00%	2



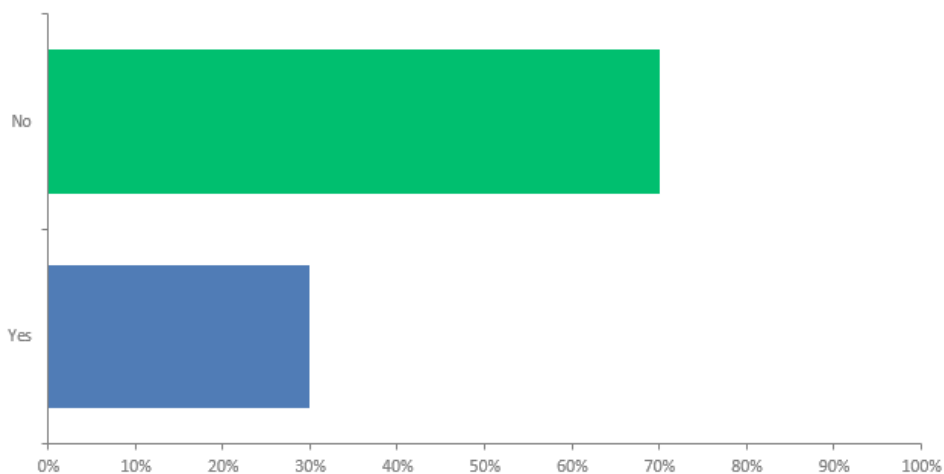
Are there planned special events within your service area that could increase QRS call volume?

Answered: 7 Skipped: 5



Do you up-staff QRS for these known busy times?

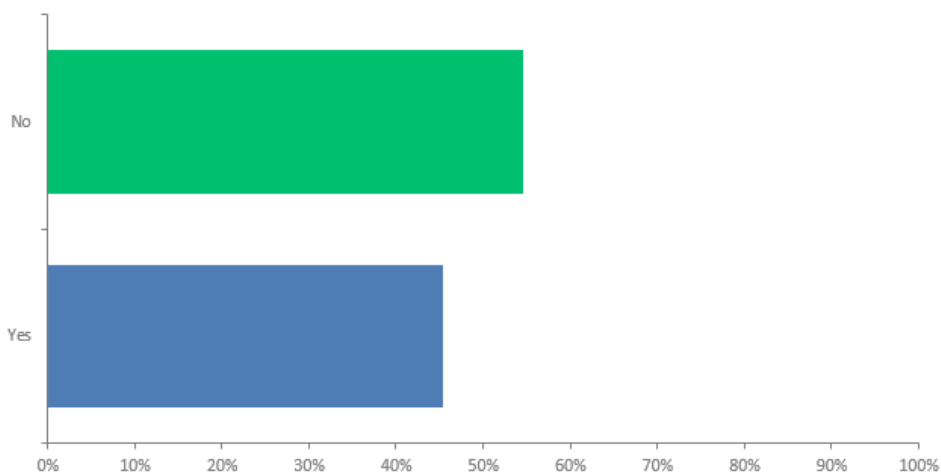
Answered: 10 Skipped: 2





Do you have a public education program in place? (First Aid/CPR/EMT/etc.)

Answered: 11 Skipped: 1



Nearly half of respondents report offering educational programs within their communities. Outreach efforts targeting schools and civic organizations provide valuable engagement opportunities and can be effectively leveraged to support recruitment efforts. Consistent and sustained community messaging through these programs has the potential to positively influence workforce availability and help address ongoing personnel challenges.



What educational programs are provided?

Answered: 6 Skipped: 6

RESPONSES

- 1 First aid - Cub scouts, Boy scouts, Brownies and Girl scouts. Fire prevention to the Punxsutawney area School district.
- 2 CPR
- 3 Mock crash for prom, recruitment day at the school, national night out, fire prevention week
- 4 CPR /First Aid
- 5 N/a
- 6 CPR/FA/AED

How often do you provide public education and to what audiences?

Answered: 6 Skipped: 6

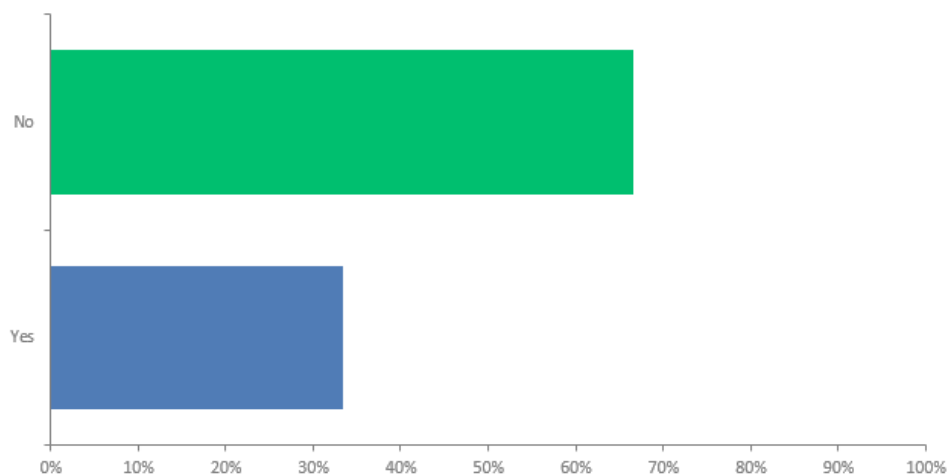
RESPONSES

- 1 A few times per year
- 2 Just members
- 3 4-6 times per year
- 4 By request
- 5 N/A
- 6 1-2 times per year



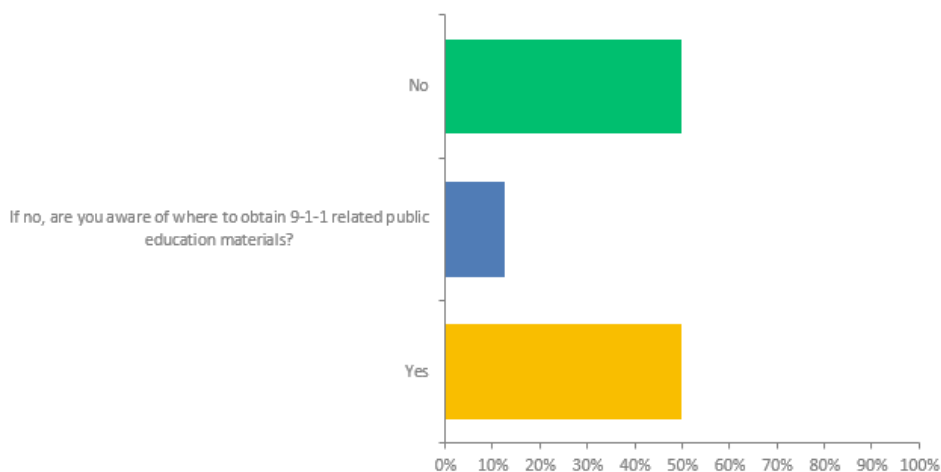
Do you coordinate your public education sessions with any other public safety groups?

Answered: 9 Skipped: 3



Does your public education material include when to call 9-1-1 and what constitutes an emergency?

Answered: 8 Skipped: 4





How much time does a "typical" QRS call take?

Answered: 9 Skipped: 3

#	DISPATCH TO ON SCENE	#	AVAILABLE AND BACK IN COVERAGE/ RESPONSE AREA
1	Average 10 min	1	Average 30 to 40 min
2	Depends on location of our 72 <u>sq.miles</u> same	2	30 to 60 minutes
3	10 to 30 minutes depending on location	3	1 hour
4	3-5 minutes	4	30-40 Min
5	5-10 minutes	5	15
6	6-12 Min	6	1 hour
7	10		
8	2-8 minutes, 12-20 in the most outer areas of our district		
9	10-20 min		

Typical responses range from 5–20 minutes for arrival, with total call cycles averaging 30–60 minutes, reflecting efficient use of limited resources. Agencies providing QRS services often favor this model because it allows them to deliver meaningful patient care with a more flexible and manageable level of commitment. This structure supports sustained participation while still ensuring timely and effective service to the community.



In the past three years [2023-2024-2025], how often have QRS calls in your primary territory been declined/turned over?

Answered: 8 Skipped: 4

RESPONSES

- 1 5% to 10% mainly daytime calls
- 2 0
- 3 5
- 4 0
- 5 My guess is 6-10
- 6 0
- 7 0 - Zero
- 8 15

In the past three years [2023-2024-2025], how may call-outs has your QRS service responded to?

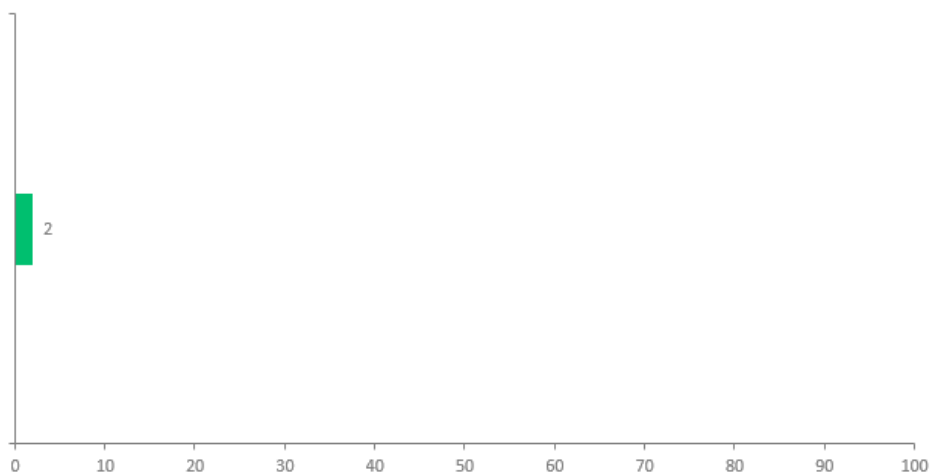
Answered: 5 Skipped: 7

#	2023	#	2024	#	2025
1	109	1	102	1	77
2	14	2	16	2	15
3	119	3	120	3	125
4	31 plus 37 <u>mva</u>	4	19 plus 33mva	4	26 plus 31 <u>mva</u>
5	80	5	82	5	78



What is the average number of QRS calls handled per week by your organization?

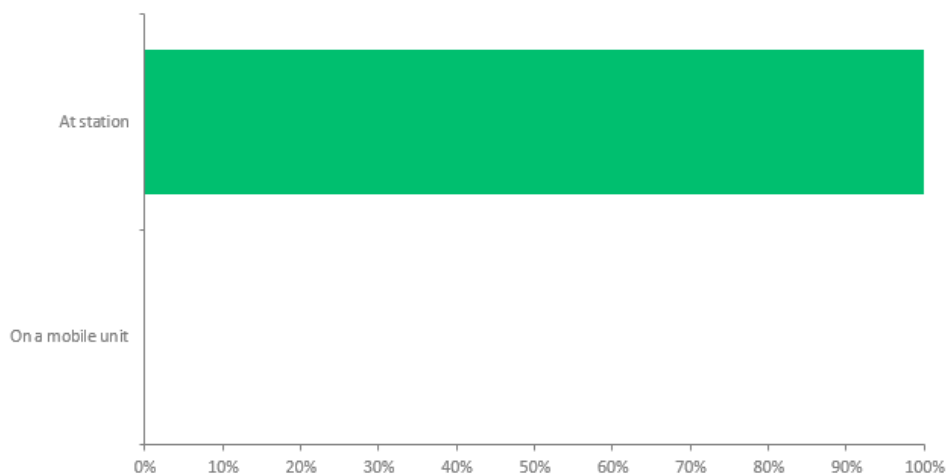
Answered: 4 Skipped: 8



The small number of quick response service support calls represents low frequency, but high-importance incidents, not uncommon in rural systems.

Where do you complete your patient care report (PCR)?

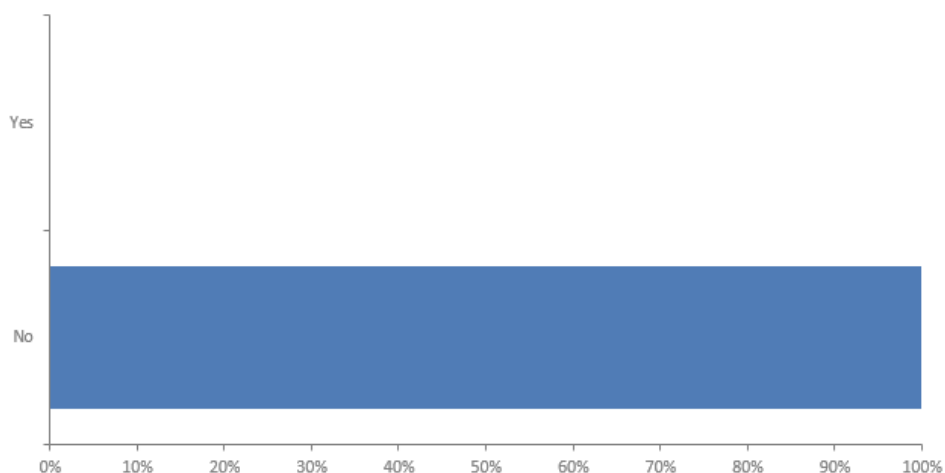
Answered: 8 Skipped: 4





Do you have a QRS recruitment program in your fire service?

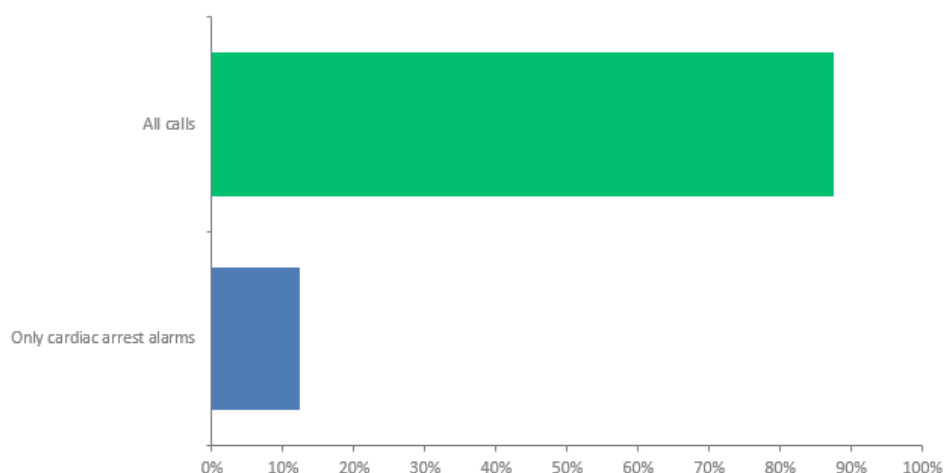
Answered: 9 Skipped: 3



QRS services are commonly embedded within fire departments as an additional level of response. However, the lack of a structured pipeline for onboarding new responders represents a significant risk to long-term system sustainability.

What types of medical calls does your fire service provide QRS?

Answered: 8 Skipped: 4





Most respondents offered that they respond to all EMS calls for service. While response to all calls is more demanding on the service, it is not uncommon in a rural healthcare setting where EMS unit response times may be extended due to range or crew availability. Some departments specified that they respond to calls classified by emergency medical dispatch as Charlie, Delta, and Echo calls, all of which are critical acuity. Applying a limited range of responses to calls with higher acuity would reduce the demand on departments without significantly impacting patient care.

What intervention can your QRS provide?

Answered: 7 Skipped: 5

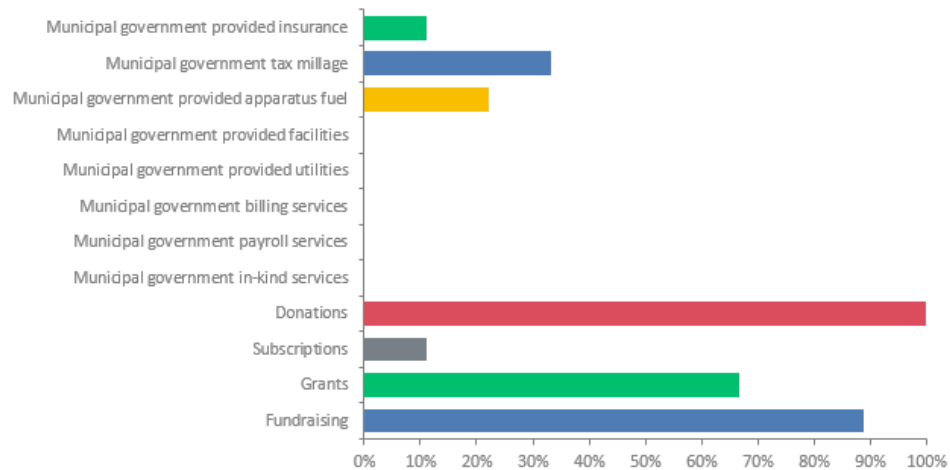
RESPONSES

- 1 BLS
- 2 BLS
- 3 BLS skills
- 4 BLS
- 5 BLS
- 6 CPR/AED/First Aid
- 7 Epi, AED, c-pap, Narcan, Albuterol



Please indicate where your service receives support (financial/in-kind/insurance/etc.) from your municipal governments, donations, grants, etc.? [Select all that apply]

Answered: 9 Skipped: 3



Funding relies heavily on donations (100%), fundraising (89%), and grants (67%), with limited municipal support. This highlights a highly unstable funding model, dependent on non-guaranteed revenue.



How much of your organization's overall budget is provided by the municipality(ies)?

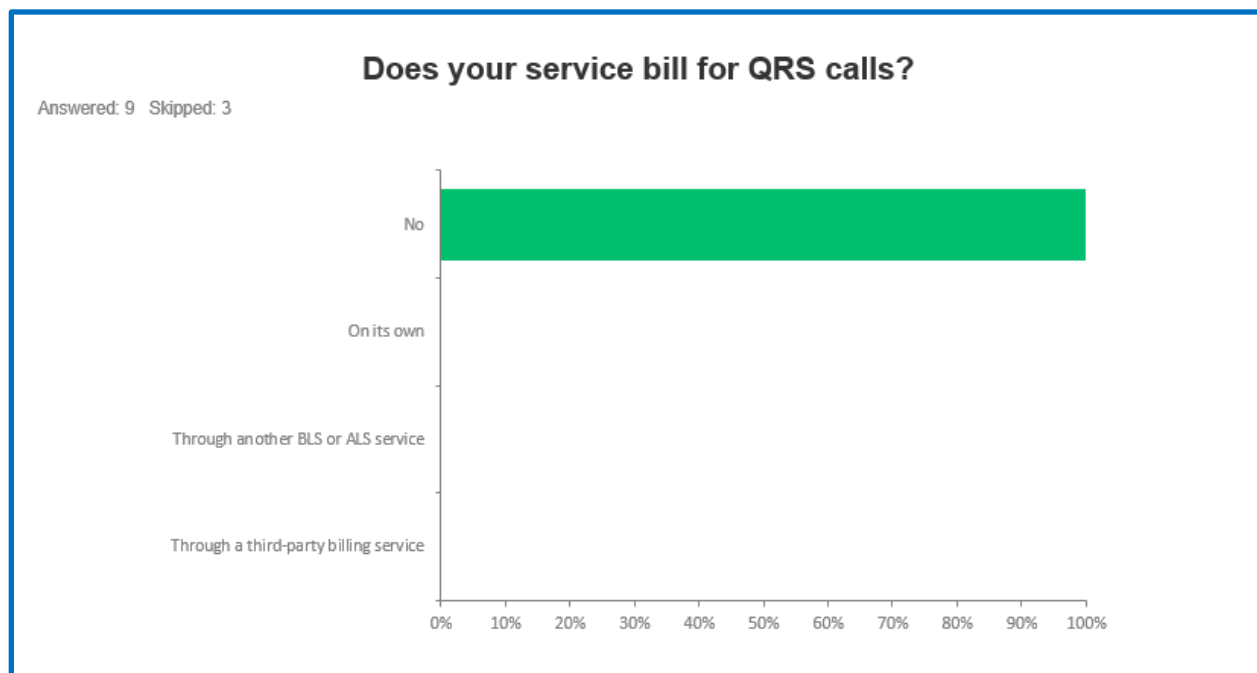
Answered: 8 Skipped: 4

#	INSURANCE	#	TAX MILLAGE	#	IN-KIND SERVCIES
1	0% The Twp Provides Workers Compensation	1	.5 Mill	1	\$3500.00
2	10%	2	0	2	\$2500 fuel per year
3	0	3	0	3	12,000
4	0	4	0	4	0
5	Workers comp we cover our own insurance after that			5	Fuel
6	0			6	0
7	Workers comp			7	\$7000

What amount is needed to financially cover your per-QRS-call costs?

Answered: 3 Skipped: 9

#	RESPONSES
1	\$20,000 per year.
2	Depends on what you use for the call. Some calls it would be \$50 others could reach \$200.
3	\$350-\$500

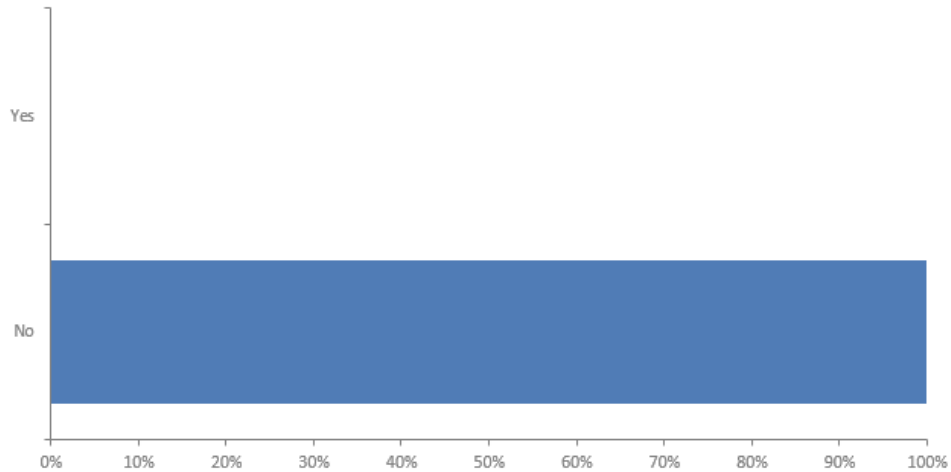


A fire department operating a QRS in Pennsylvania generally cannot bill in the same way a transporting ambulance service can, and reimbursement is limited and payer dependent. This can create a revenue gap, meaning services operate at a loss.



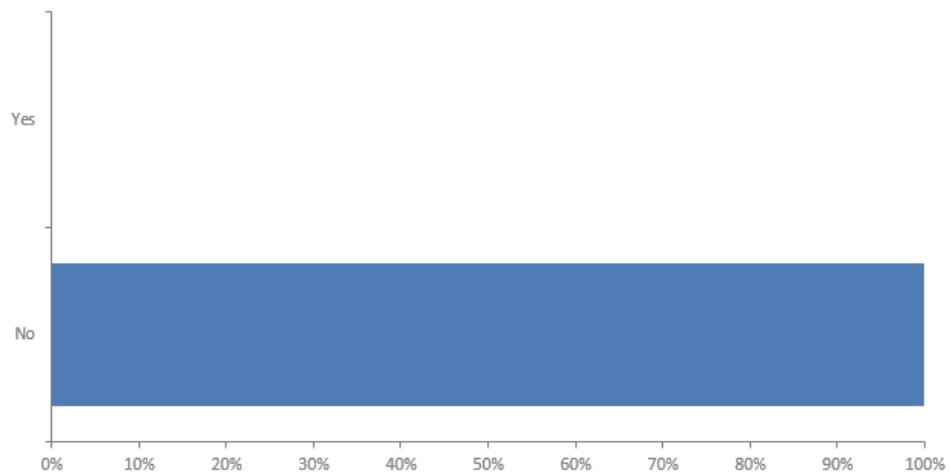
Are QRS volunteers provided a stipend of any kind?

Answered: 10 Skipped: 2



Has your service ever participated in a busy study, a heat-map, or predicative call location study?

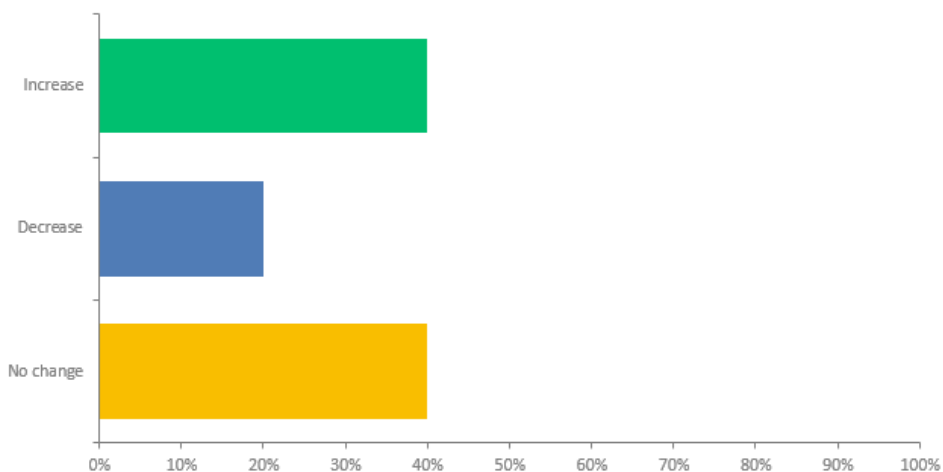
Answered: 10 Skipped: 2





Have you seen an increase or decrease over the last three years in the number of medical calls?

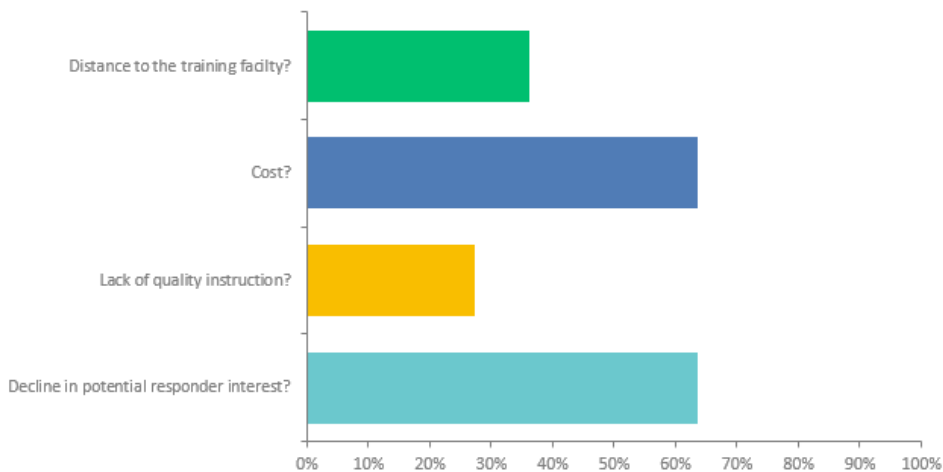
Answered: 10 Skipped: 2



Calls are stable or increasing slightly, and indicate demand is not declining, reinforcing long-term sustainability concerns.

EMS training requirements have been ranked near the top as one of the most significant issues faced by agencies across the nation. In your opinion is this issue due to [Select all that apply]:

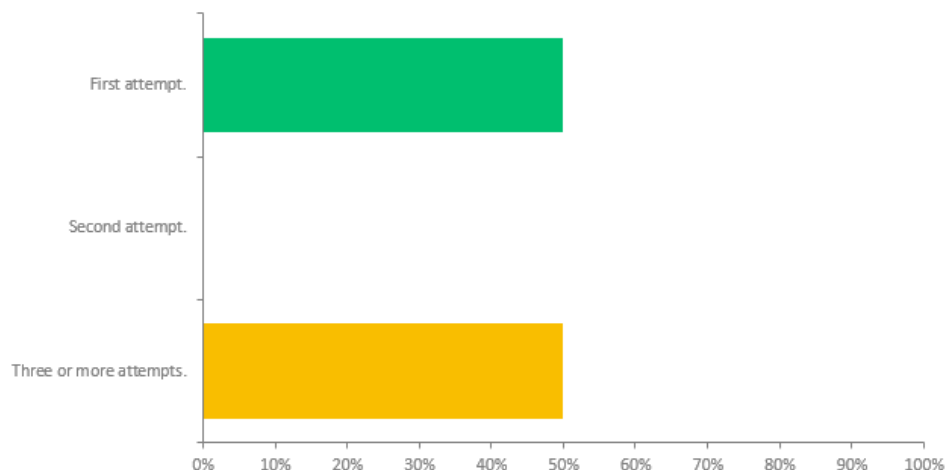
Answered: 11 Skipped: 1





What is the pass rate on EMS training within your agency?

Answered: 8 Skipped: 4



In what areas do you need assistance from municipal or county government?

Answered: 5 Skipped: 7

RESPONSES

- 1 Financial due to the rising costs of equipment, utilities, fuel and insurances.
- 2 Recruitment
- 3 Financial
- 4 The current assistance meets our departments needs
- 5 All - They provide nowhere enough funding to even pay for needed yearly expenses for our dept.



Are there any other comments or information you would like to provide?

Answered: 3 Skipped: 9

RESPONSES

- 1 The rising cost must be delt with, especially apparatus.
- 2 Can discuss at the meeting. The current training setup
- 3 A look at training is needed for FR's to treat and care for a Pt in the field and transport to the nearest hospital. Funding as well as the lack of reimbursement is a huge problem.



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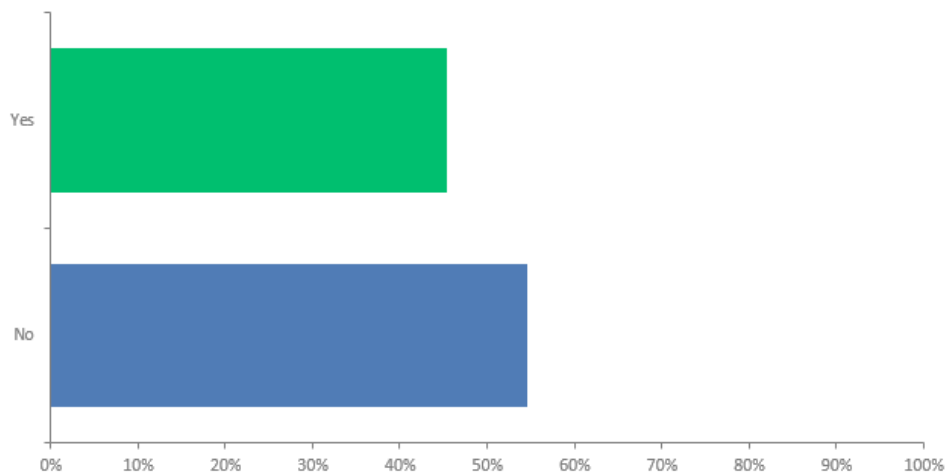
Municipal/Elected Officials

Workforce Solutions NC, PA EMS study - Municipal/Elected Officials



Do you have formal agreements or contracts with EMS providers?

Answered: 44 Skipped: 0



A majority (54.55%) of municipalities report no formal agreements with EMS providers, while only 45.45% do. This indicates a structural gap in accountability and service definition. Many municipalities rely on informal arrangements, which can lead to unclear expectations, funding instability, and inconsistent service delivery.



What is your level of involvement with the EMS agency(ies)?

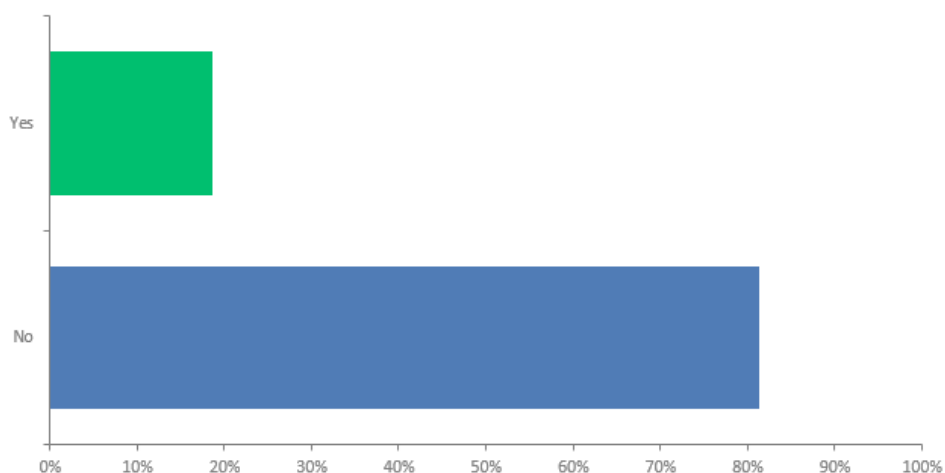
- | | |
|---|--|
| 1 We are members of the Coudersport Volunteer Ambulance Association | a monthly meeting to answer questions and provide statistics for calls in Ferguson Township. |
| 2 Provide Worker's Compensation | 21 Financial and budgetary review. |
| 3 None | 22 We have our own police force, and the fire department gives the Board a monthly report. |
| 4 EMC Assistant Coordinator | 23 POC / Processing required documents, including review, financial review and projections, execution and maintenance. |
| 5 Mainly through working relations with fire department and Jefferson County DES | 24 The township distributes Foreign Fire Insurance received to the three fire departments that serve the communities. |
| 6 Township pays workmen's comp insurance and gets regular reports from the agency | 25 None |
| 7 Not much | 26 Pass information to ems coordinator |
| 8 Little as possible. They contact if needed | 27 We own the Fire Depat., I have sat on the Ambulance Board, and we do have an Emergency Management volunteer for our Borough, and I do attend the LEPC. We have a full time Police Dept. |
| 9 we recently added a tax to the township to help support the ambulance | 28 We help to fund them. |
| 10 UNKNOWN | 29 limited |
| 11 Jefferson County EMS is our provider, but we are not aware of a formal contract. | 30 Monetary support |
| 12 Minimal | 31 Chief Officer and current EMT |
| 13 Life member | 32 None |
| 14 None | 33 Heavy |
| 15 None | 34 The township is in the process of appointing a coordinator. |
| 16 None | 35 township supervisor on ambulance board |
| 17 SME of the municipality | 36 We are very involved with our local volunteer fire company; in fact, the fire company President is our Board Chairman |
| 18 None | |
| 19 Make sure they have the information for grants, provide insurance coverage for the vehicles | |
| 20 Pay each company 1/2 of the Foreign Fire Relief money and paying the annual contract amount. At least, one time per year, representatives attend | |

Responses indicate varying levels of municipal involvement, with some providing financial support and governance participation. This diversity presents an opportunity to build greater alignment and enhance collaboration, supporting stronger regional planning and system-wide advancement.



Does your municipality have representation on the EMS boards or committees?

Answered: 43 Skipped: 1

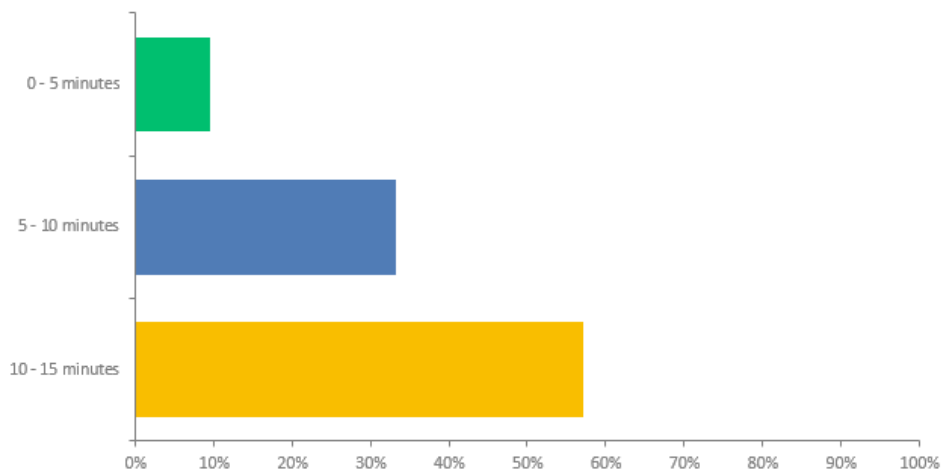


Only 18.6% of municipalities have representation on EMS boards, while over 81% do not. This reinforces a major disconnect. Municipal decision-makers often do not provide direct oversight or influence on EMS operations, despite being key stakeholders or funders.



What is your expectation of EMS response times (from dispatch to arrive on scene) within your municipality?

Answered: 42 Skipped: 2



Most respondents anticipate response times in the 10–15-minute range (57%), with fewer expecting shorter intervals. This reflects a realistic understanding of service delivery in rural environments, where longer response times are common. Overall, these expectations suggest stakeholders have an informed awareness of current system capabilities and constraints.



How would you describe the level of EMS service your municipality currently receives?

Answered: 41 Skipped: 3

RESPONSES

- | | |
|--|---|
| <p>1 Fair</p> <p>2 Adequate</p> <p>3 Great</p> <p>4 Great.</p> <p>5 Both services are respectable. Due to limited crews sometimes there is delay Warsaw Township is located between both agencies. We are fortunate in that regard.</p> <p>6 Providing agency is only one ambulance and one EMT. Area is covered by second due when that EMT is not available. Second due agency is app 20 miles away. We do the best we can with what we have.</p> <p>7 Good for the distance, sometimes unavailable, doing the best they can</p> <p>8 Good</p> <p>9 Average</p> <p>10 We are very rural and the EMS service that is provided go above and beyond to service our remote area</p> <p>11 Usually only 1 Ambulance staffed for our area of the county. Fire Department QRS is used frequently to help provide quicker patient care until an ambulance can respond.</p> <p>12 Excellent</p> <p>13 Very good!</p> <p>14 Good</p> <p>15 Sufficient</p> <p>16 High</p> <p>17 No complaints</p> <p>18 Exists at a bare minimum</p> <p>19 ok</p> <p>20 MODERATE</p> <p>21 Good</p> | <p>22 All Volunteer</p> <p>23 Spectacular service.</p> <p>24 Great response from police department. Fire department has a quick response but is sometimes few in number. Ambulance services seems to be spread thin.</p> <p>25 Based on volunteer / per diem status EMS providers struggle with rural geography, volunteer rosters and demographics.</p> <p>26 sufficient</p> <p>27 very good</p> <p>28 Na</p> <p>29 BLS- Basic Life Services</p> <p>30 We are happy with it</p> <p>31 Very good</p> <p>32 poor lack of EMS personal</p> <p>33 Our borough Emergency Management volunteer is limited. As for the County I feel they do a great job.</p> <p>34 The number of people who are trained and available is dwindling. The fire departments rely on volunteers and many of them are aged.</p> <p>35 It is limited. We only have one company who serves us.</p> <p>36 We have excellent EMS service in Fox. They cover our town well.</p> <p>37 Good</p> <p>38 Slow but reliable.</p> <p>39 We have an agreement with Sigel Vol Fire Department</p> <p>40 good</p> <p>41 Top-Notch</p> |
|--|---|

Descriptions of the current system span a wide spectrum, ranging from “excellent” to “bare minimum,” with many respondents pointing to persistent staffing shortages, the realities of rural service delivery, and the limitations of a largely volunteer-based workforce.

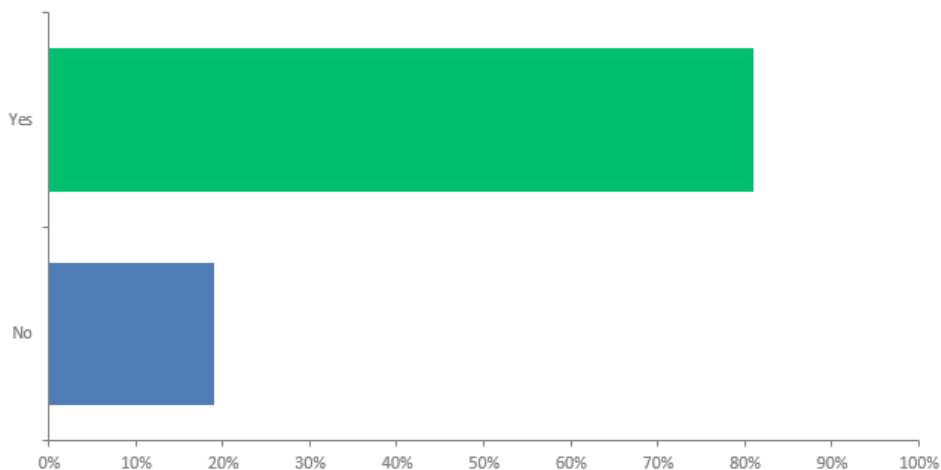
There is a common recognition that service delivery is generally meeting community needs, but doing so requires effort, adaptability, and, in many cases, informal workarounds. These may include extended shifts, reliance on mutual aid, or the continued dependence on a small group of highly committed responders. As a result, the system can be characterized as functional yet sensitive to disruption.

Overall, this perspective suggests a system that delivers acceptable outcomes in the present but may face challenges sustaining that level of performance over time without strategic investment and structural reinforcement.



Is your municipality satisfied with the level of EMS service provided?

Answered: 42 Skipped: 2





What metrics do you use to measure the effectiveness of EMS in your municipality?

Answered: 21 Skipped: 23

RESPONSES

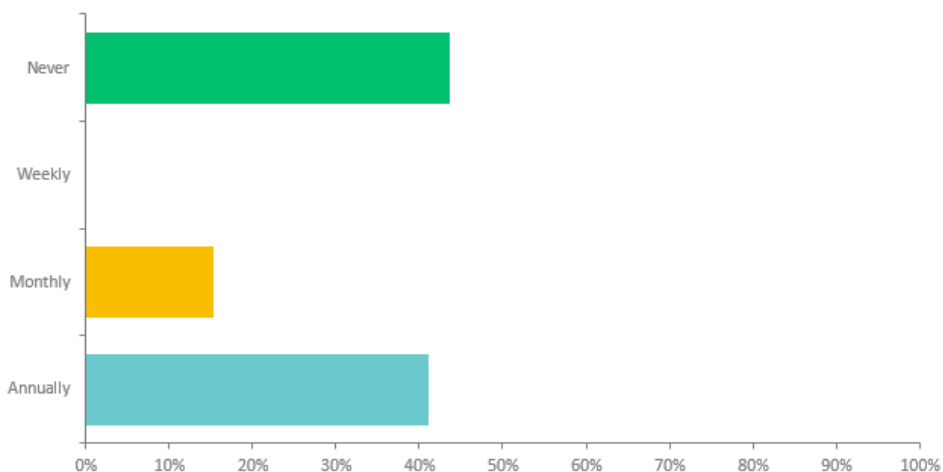
- | | |
|--|--|
| 1 Emergency Operations Plan Book | outlining the total amount of calls / dispatch specs as well as the financial end of billing. |
| 2 Public input | 17 Most of the emergency calls that are responded to EMS is accidents on Interstates or State Highways. The emergency calls for the communities are low. |
| 3 Response time | 18 response time and service to residents of Bradford |
| 4 Complaints or lack thereof | 19 We don't, other than attending the LEPC meetings. |
| 5 Look at number of calls received in a one-year period and what percentage were referred to second due when local ambulance is out of service. Amount of time ambulance is placed out of service due to no EMT. | 20 Communication between EMA, Fire Department, and Supervisors to discuss |
| 6 Feedback from township residents | 21 resident feedback |
| 7 UNKNOWN | |
| 8 Currently none, Just what we here from radio transmissions. | |
| 9 Number of complaints received | |
| 10 Training and turn overs. | |
| 11 Personnel observation, reports from citizens | |
| 12 none | |
| 13 Response time and number of people who respond | |
| 14 None | |
| 15 Response times and service reports via delegate to Board | |
| 16 The EMS providers supply a YTD comparison from previous years | |

Many municipalities report having limited or no formal performance metrics in place, while others rely primarily on basic indicators such as response times or the tracking of community complaints. This variability highlights an opportunity to strengthen data-informed oversight and develop more consistent evaluation frameworks. By expanding the use of standardized performance measures, municipalities would be better positioned to objectively assess EMS system performance, identify areas for improvement, and support more strategic, evidence-based decision-making.



How often do you review EMS performance reports?

Answered: 39 Skipped: 5

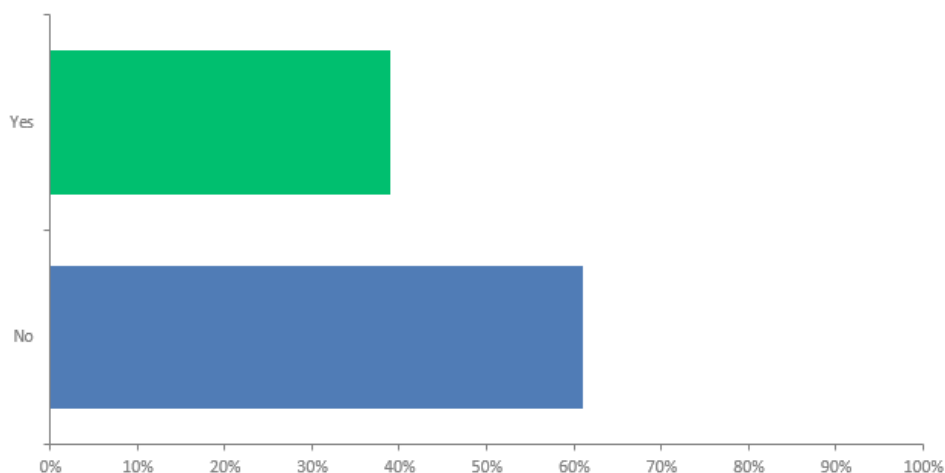


Responses indicate a minimal continuous oversight or awareness, reinforcing an opportunity to build a governance structure and ongoing accountability and support.



Have you received any complaints, compliments, or other feedback from residents about EMS services?

Answered: 41 Skipped: 3

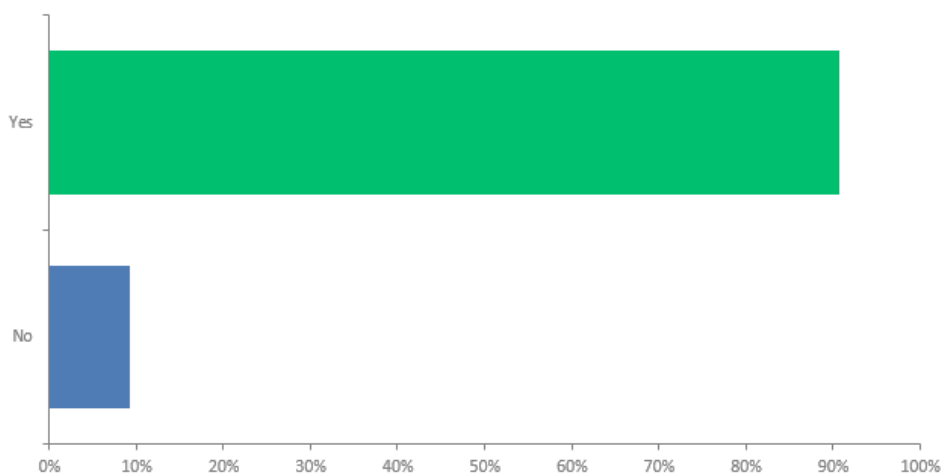


- Time
- Thanking EMS for their service
- Lack of ambulance
- EMS goes above and beyond to meet the needs of our residents
- Turn overs. Waiting for an ambulance from out of area.
- Mostly on professionalism
- Residents are grateful for the volunteers
- Many compliments. Our community voted through referendum ballot in providing financial support to the Ambulance Corps annually.
- Lead Time, EMS Unavailability - ultimately due to demographic.
- Cost to the township
- Compliments on their services
- Lack of ambulance
- They do a great job but need more help.
- Some complaints about medic services
- Happy we have local service
- Numerous compliments - efficient, professional personnel

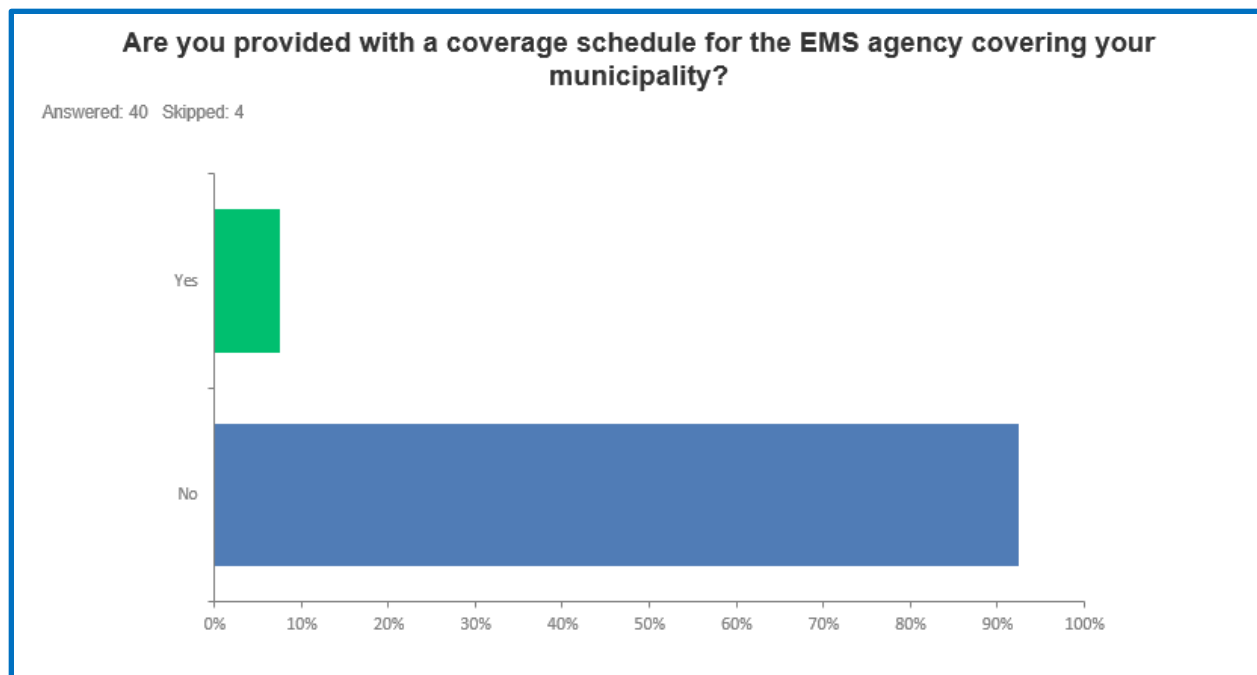


Are EMS response times and service quality meeting your expectations? If not, what improvements would you like to see?

Answered: 43 Skipped: 1



- Again - expectations are met when service is in service.
- A second Ambulance crew on hand as they did in the past.
- JCEMS has trucks, but they only staff one unit most of the time.
- The first crew out is great. If we need another crew, we normally have to dispatch an ambulance from outside of the area.
- Better staffing.
- Units kept indoors, operating on a schedule and not by the seat of his pants.
- They are slow, but it's also a volunteer department so that is expected
- The service provided is excellent.
- The complaints / negative response we get always involve the arrival time of units in comparison to when the actual emergency was reported.

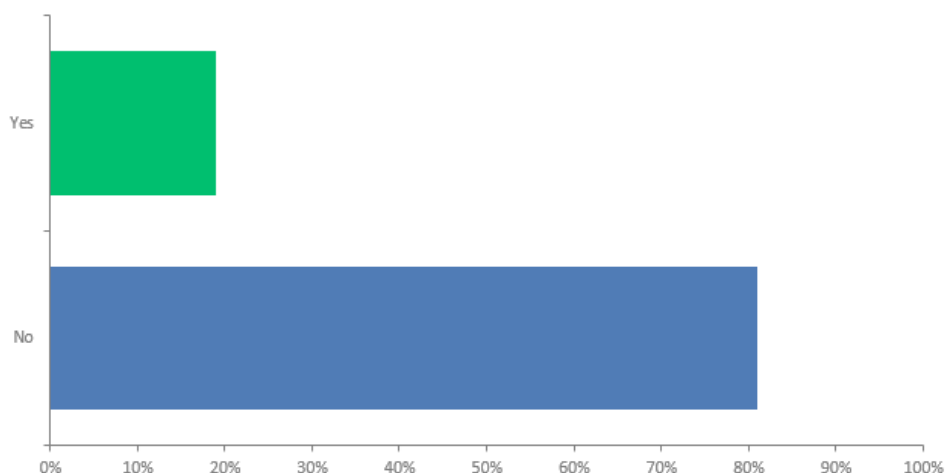


Only 7.5% of municipalities receive coverage schedules, while more than 92% do not. This gap presents a clear opportunity to improve communication and transparency, as greater awareness of coverage availability would support more proactive planning and risk mitigation. Enhancing the consistency of schedule sharing could strengthen coordination and help municipalities make more informed decisions related to EMS service support and preparedness.



Do you communicate EMS service levels and changes to your residents?

Answered: 42 Skipped: 2



Municipalities play an important role in maintaining transparency and fostering public trust. Proactively communicating EMS service gaps or changes is a key component of that responsibility. Providing clear, consistent information helps residents better understand current system capabilities, set realistic expectations for response, and make informed decisions about when and how to access emergency services. Effective communication can also support community awareness, encourage appropriate system utilization, and build support for necessary funding or policy changes. When approached thoughtfully, this type of engagement strengthens the relationship between local government, service providers, and the community while contributing to more informed and resilient public safety systems.

- The ambulance association has sent out several letters to all taxpayers outlining issues and challenges that the service is facing and requesting volunteer assistance for various roles within the service.
- Discuss concerns as they arise.
- Meetings and letters.
- We know that the Ambulance has a schedule of per diem volunteers - the schedule is curated around the historical data of highest volume calls.
- The Fire Company and Ambulance Association both work due diligently on providing our community with updates on social media, local governmental meetings, community involvement, and events etc.



- By letter or phone calls.
- Talk with residents.

What level of transparency do you expect from EMS agencies regarding coverage and incidents?

Answered: 27 Skipped: 17

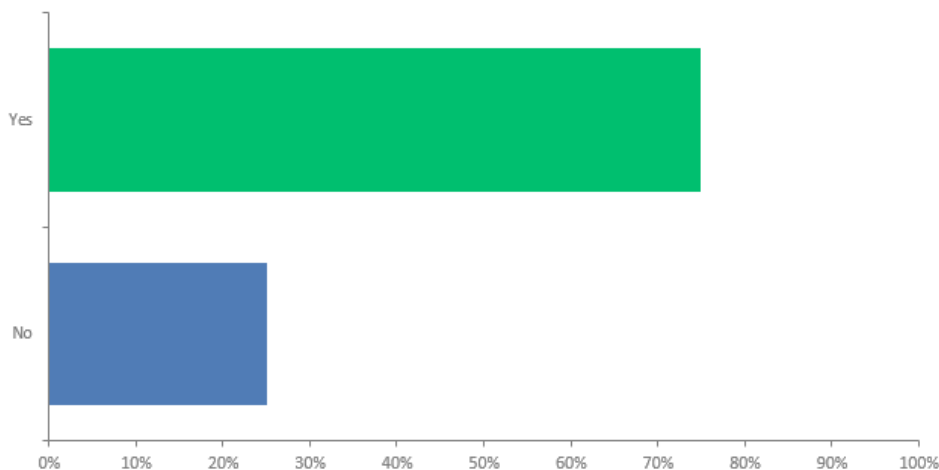
RESPONSES DATE

- | | |
|---|---|
| 1 Full transparency | 14 To be able to cover all calls within our Township at any given time. |
| 2 Provide information needed | 15 Any question honestly answered |
| 3 Yearly reports of spending | 16 They keep us in the loop |
| 4 If it is need to know, then they would be expected to provide. | 17 Response times and service reports via delegate to Board |
| 5 A high level. The township needs to be in the loop with what is happening within the agency to be prepared for any changes that are occurring. | 18 Monthly reports |
| 6 Provide information if asked | 19 Full. |
| 7 100% 3/27/2026 | 20 To do their best and respond to calls to the best of their ability. |
| 8 Total | 21 100% |
| 9 We believe that if there are issues in our township EMS will go directly to the Supervisors for help | 22 total |
| 10 UNKNOWN | 23 N/A |
| 11 Municipalities should have more communication with our service but there is very little to no communications. a yearly report or review would be nice. | 24 The fire department has a licensed QRS to buffer the days EMS is overtaxed. |
| 12 High when requested | 25 To get told when there are issues with staffing or equipment |
| 13 High | 26 Full transparency when necessary |
| | 27 I expect confidentiality from first responders; and to be notified if any accident compromises township business |



Are you aware of staffing challenges (e.g., paramedic shortages) affecting your EMS provider?

Answered: 40 Skipped: 4



Strengthening municipal officials' understanding of EMS staffing dynamics is a critical step toward addressing system challenges. Greater awareness enables more proactive planning, including support for funding initiatives, workforce development programs, and regional collaboration efforts needed to sustain EMS service delivery over the long term.

- Council Rep has told Council of this.
- More volunteers are always needed.
- All EMS agencies are experiencing staffing shortage
- Currently there is only one EMT to respond to calls. When that EMT is not available, calls for our township go to a second due agency. Recruitment of volunteers is challenging due to ruralness of area and a very limited population base.
- Biggest problem is getting people; salary is too low
- Lack of personal
- They are understaffed and the funding is horrible, but they continue to service the community at 100%
- In the past JCEMS had 2 ambulances crewed from the station in our township as well as a transport van. Currently they usually only staff one and a lot of times rely on standbys from out of our area, increasing response times.
- Commonwealth-wide issue, probably a national one as well
- Volunteers are at a low in all 1st responders.

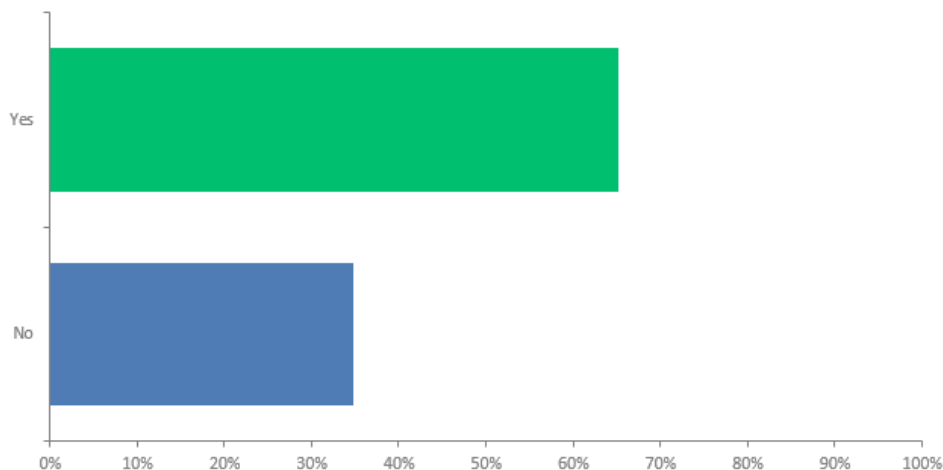


- Licensed ALS Service with only one part-time provider. Most of BLS staff are family members.
- They are volunteers.
- Lately, withing the last year, there have been notices of meetings with staffing issues being dominant.
- Training requirements from the state hinder the ability to recruit new people.
- The EMS positions are voluntary in Mahaffey, and Rescue Hose & ladder have a small group of Paid EMS workers and also utilize volunteer EMS.
- Financial support is needed for staff support and proper wages, training, equipment, supplies, etc.
- EMS services in the entire state seem to be shorthanded, in addition to all work forces.
- Yes, all. Volunteerism is at an all-time low, dedication is not what it used to be, and the economy is not sustainable as it once was to be able to volunteer.
- They are constantly short-staffed, probably due to the rural area.
- Lack of people.
- They have limited staff.
- Staffing challenges have been a topic of emergency services for MANY years. Our EMS manager and Fire Chief give an annual report at our Township meeting.
- I also run with a fire department and understand what's going on.
- Hard to find volunteers.
- More volunteers are needed.



Are you familiar with the legislative requirements to provide EMS services within your municipality?

Answered: 43 Skipped: 1

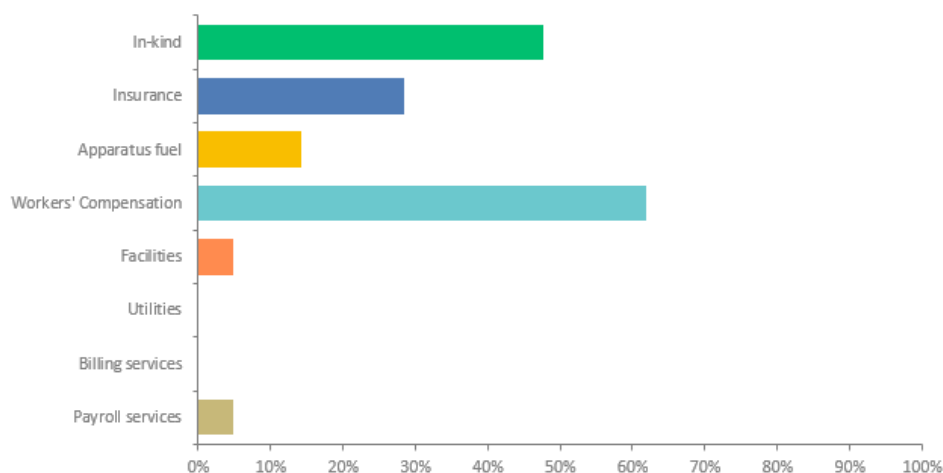


Municipalities in Pennsylvania are statutorily responsible for ensuring that EMS services are available within their jurisdictions, yet awareness of this obligation varies among local officials. While EMS is recognized as an essential public service under state law, many municipalities take a reactive approach, often engaging only when service challenges arise. This gap in understanding limits proactive planning, funding, and coordination needed to sustain EMS systems. Expanding education for newly elected and appointed officials presents a key opportunity to strengthen awareness, improve oversight, and support long-term system stability.



What level of support (financial or otherwise) do you provide to your EMS service? [Select all that apply]

Answered: 21 Skipped: 23



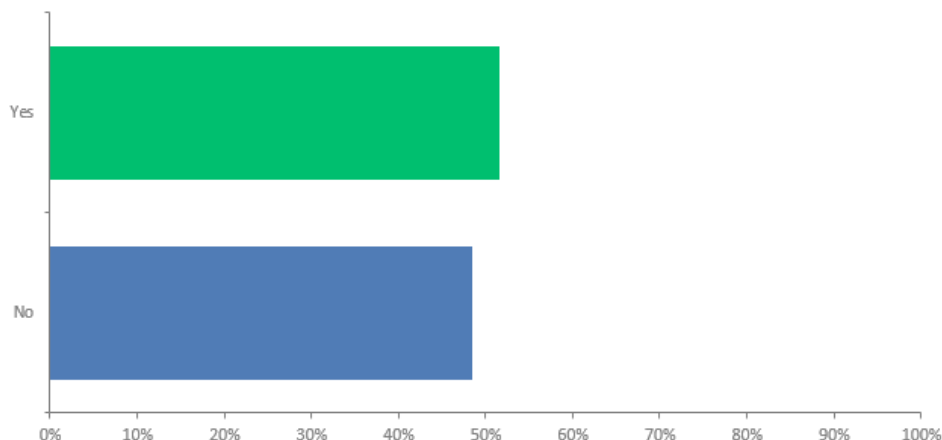
- Donation of \$930 to ambulance and over \$20,000 to FD.
- Annual contribution.
- Fire Aid.
- Donation - Act 13.
- Act 13 funds – will provide supplies if on a call in the area.
- Ambulance tax.
- We only provide funding for our Fire / QRS Service.
- Tax allotment.
- We only provide funding for our Fire / QRS Service.
- Tax allotment.
- None, the ambulance has a membership drive every year.
- None.
- They sent us a contract, and we paid \$522 for the year.
- We pay Ferguson Township's share of Workers Compensation for Ferguson Township. Each company receives 1/2 of Foreign Fire Relief and pays an annual contracted amount.
- Financial support via tax collection. Approximately \$50,000.00 annually.
- Foreign Fire Funds to Germania Fire Co.
- The Foreign Fire Insurance Premium Tax is distributed between three fire departments that serve our communities.
- Bradford Township is billed an annual service fee which is currently \$35,553.00 for 2026



- Straight donation.
- Act 13 funds, but that is going away.
- Last year we donated \$20,000
- Donations.
- Funding new ambulances.
- We have a Fire Tax in place that we give to our local fire department. We also donate to them every year.

Would your municipal government be willing to provide any financial support through "in-kind" offerings? (Paying utilities, workers compensation insurance, vehicle insurance, fuel, clerical support, billing, etc.?)

Answered: 33 Skipped: 11



- We provide Worker's Compensation.
- Already pay a quarterly contract fee that is a very high amount.
- I cannot answer for [the] Supervisors. I do know funds are limited as they are.
- Not sure what it would look like - but if the current ambulance association is not able to continue due to lack of volunteers, we may need to work with an outside agency or cooperative to provide service. Whatever the township could do to help facilitate this would need to be identified and addressed. The township itself is having difficulties finding folks to run for supervisor and fill other township related roles.
- No budget.
- We are also a small struggling township.
- Already pay workers compensation for Columbia Fire Company.
- We would be willing to look into helping with funds if needed.

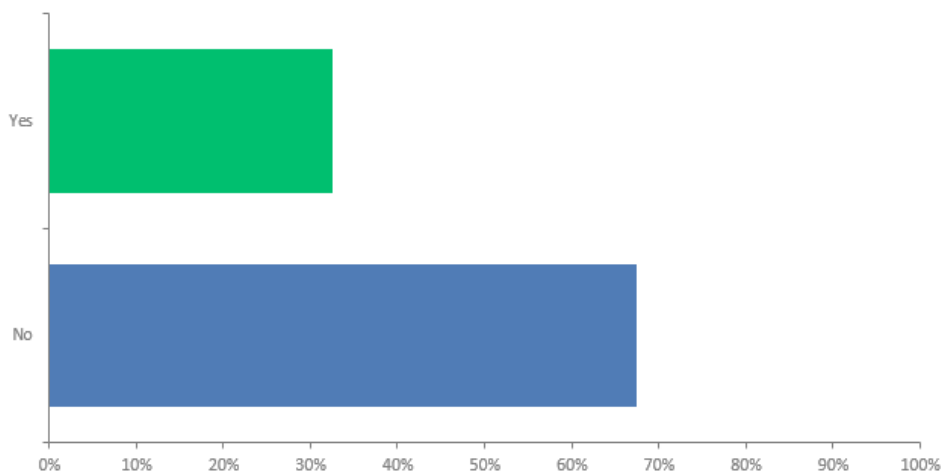


- If accepted through the budgetary process.
- Lewis Run Borough gives donation to cover water, sewer and refuse for year.
- Unable to answer that question at this time. The ambulance is charging for their services and paying their EMTs and Paramedics. They also have a yearly fund drive.
- Lack of credibility of the service owner - incorporated for profit.
- We do currently pay workers' compensation for our volunteer firemen.
- We do pay worker's compensation for Mahaffey.
- We currently provide approximately \$50,000 in financial support annually. Specifically, for paying appropriate wages and benefits.
- Yes.
- Our budget is small.
- Maybe, only if the cost would offset the annual cost currently.
- No. Would have to go thru a board meeting.
- I would be okay with it. But it would have to go in front of the board and how they felt.
- Maybe, we are a pretty poor township, and our agreement going forward will be half a mil.
- We would be open to discussions.
- We have limited money.
- As indicated above, we do now.
- Township covers fuel for QRS.
- We already provide some of the services.
- We already pay workers comp insurance and some vehicle fuel. The millage gives them approximately \$42,000/year.



Is there a tax assessed for EMS services within your municipality?

Answered: 40 Skipped: 4



What do you expect in return for the support you provide to EMS?

Answered: 26 Skipped: 18

RESPONSES

- | | |
|---|--|
| 1 Fire and Ambulance Response in a timely manner. | 12 Adequate service |
| 2 Nothing | 13 To adhere to the minimum of EMS regulations |
| 3 Funds to be properly spent on actual needs and personnel trained properly. Not wasting the money on unnecessary spending. | 14 Respond to 911 calls |
| 4 Service | 15 Continued services within the community. |
| 5 Transparency in reporting finances, call volume, performance issues | 16 A monthly report |
| 6 Continued service | 17 Quality of Service, Dependability |
| 7 Do their job if they can, nothing above ability at that moment | 18 To do their best and respond to calls to the best of their ability. |
| 8 Nothing more than they already offer, they go above and beyond to help our community | 19 Good, trained EMS provider |
| 9 A reasonable response time, good equipment, and a trained crew. annual reporting to the municipality | 20 Again it depends on services. |
| 10 Quarterly or annually reports | 21 nothing |
| 11 Good response times | 22 Adequate EMS services to our community, which we do receive. |
| | 23 Basic services |
| | 24 A timely manner in response time |
| | 25 Assistance when ever need for our residence |
| | 26 24/7 coverage |



How much funding does your municipality allocate to EMS annually?

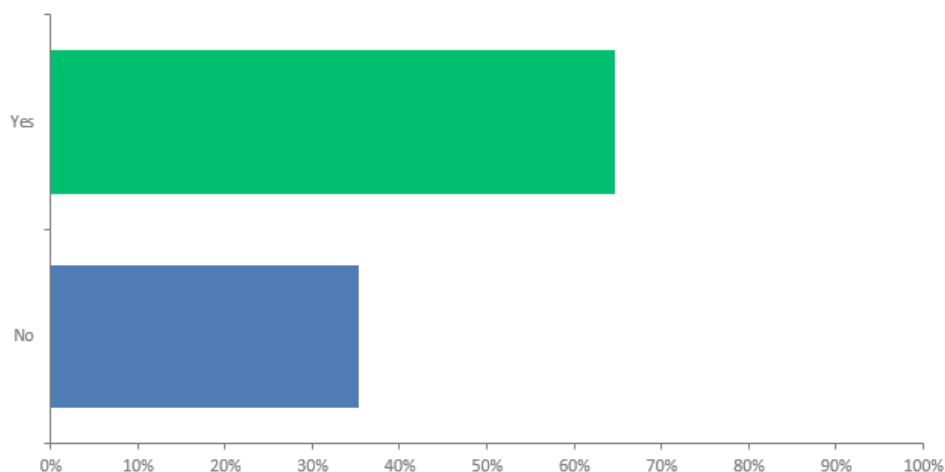
Answered: 34 Skipped: 10

RESPONSES

- | | |
|---|--|
| 1 ~\$25,000 | 20 We have a specific fire tax that is passed along to the fire department and fully fund our own police department. Traveling for work so I do not have the specific numbers. |
| 2 \$2,600 | 21 \$24,152 |
| 3 Worker's Compensation | 22 Average \$582 |
| 4 \$22,000 roughly | 23 annual billing |
| 5 0 | 24 1.5 Mills |
| 6 Varies | 25 Just workman's comp |
| 7 Have not been asked in a while - only have Act 13 money | 26 12,000 |
| 8 \$3500 from tax | 27 Our Fire Department we support approx. \$150,000, Police \$180,00, Ambulance \$25,000. |
| 9 \$4000/yr. to Columbia Fire Company | 28 It varies depending on what they need. |
| 10 0 | 29 quarterly donations |
| 11 Varies | 30 \$65,000 |
| 12 \$8,000 | 31 The funding for the fire department includes the QRS service |
| 13 None | 32 7200 plus worker's comp |
| 14 Zero | 33 Our Foreign Fire monies and the Fire Tax plus donations. |
| 15 \$1000/per year donation to Moshannon Valley EMS | 34 1.5 mills; approximately \$42,000/year |
| 16 0 | |
| 17 \$3,600 a year plus fuel and insurance and work comp | |
| 18 \$11,250.00. This amount is for the Volunteer Fire Department and EMS. | |
| 19 Approximately \$50,000.00 | |

Would you consider alternative funding models (e.g., subscription, shared services)?

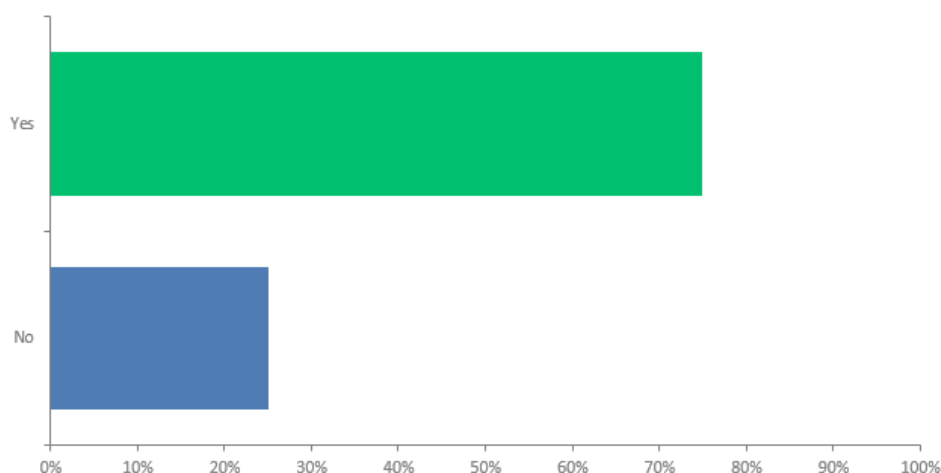
Answered: 34 Skipped: 10





Would your municipality be willing to work with an EMS agency outside of your municipality?

Answered: 36 Skipped: 8

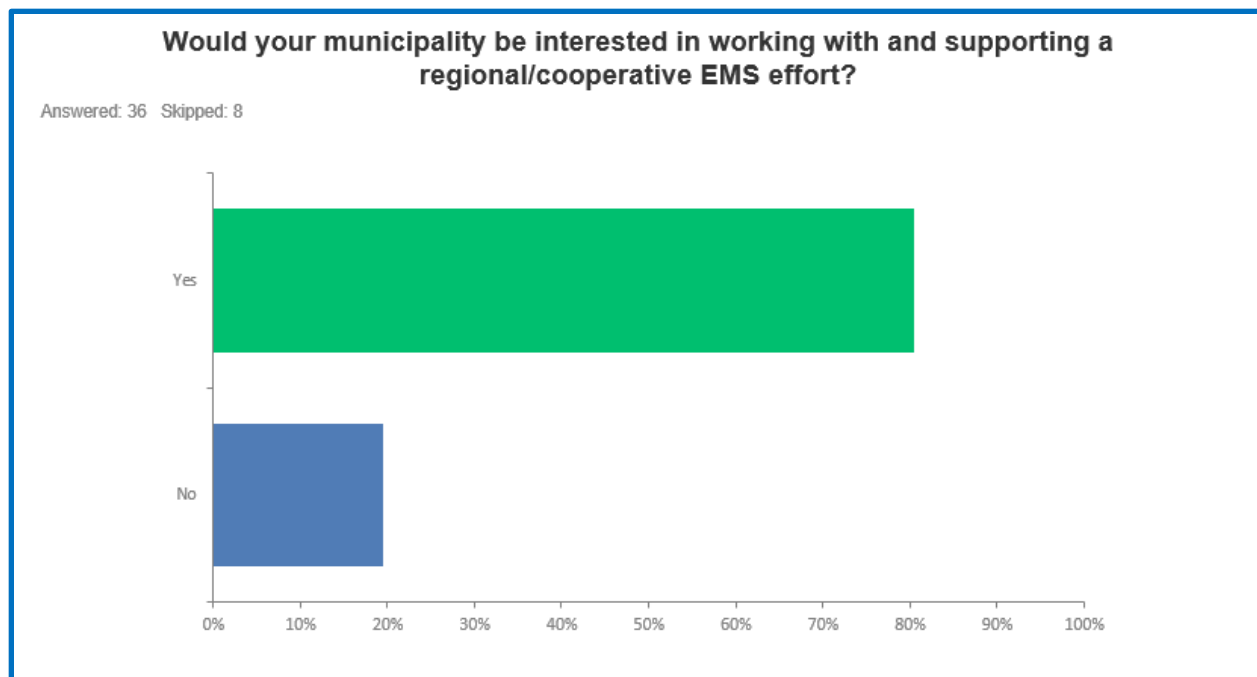


How would you define fair cost-sharing among municipalities?

Answered: 28 Skipped: 20

RESPONSES

- 1 Based on population.
- 2 We are the largest township that gets EMS services by the Fire & Ambulance Service in our area. However, our cost is way higher than the rest in the area.
- 3 Not all municipalities would provide assistance. In many municipal officials' minds, it is a service that has been provided, EMS should continue to provide.
- 4 Look at population (both resident and seasonal), call volume per municipality. Monetary amount an EMS tax would bring in that could be dedicated to cost sharing.
- 5 Per capita without raising taxes
- 6 per budget
- 7 each municipality should pay the same, either by population or by household / business
- 8 According to population and coverage
- 9 Budget determines
- 10 TBD
- 11 based on population
- 12 The level of financial support should be based on service calls and population density, as well as distance traveled.
- 13 Cost based on population
- 14 Statistics / Response Ratio of residences / population
- 15 I can not answer this question. Our township is very small and our budget is likewise. Our population is about 60 people. I can only speak for myself; I subscribe for local ambulance service.
- 16 share the cost based on usage of service
- 17 I think the fairest would be a per call assessment. Our township averages 40 calls per year, but neighboring townships have upwards of 200 calls per year. a straight mil isn't fair.
- 18 We base on assessed value and population
- 19 A per capita rate.
- 20 That's a difficult answer that must evaluate population, strains on services, types of services offered, size of the area being covered just to name a few.
- 21 Per capita plus call volume
- 22 Splitting cost of coverage area by population
- 23 We are one of the smallest township in Jefferson County and we fully support our nearest local fire department to the best of our ability.
- 24 this is something that would have to be worked out. Hopefully, it won't come to this.



A regional or collaborative EMS approach offers a strategic pathway to improving coverage, efficiency, and sustainability across service areas. By sharing resources, staffing, and operational coordination, agencies can better manage demand variability and reduce gaps in coverage, particularly in rural or resource-constrained communities. Collaboration enables more consistent service delivery standards, enhanced training opportunities, and stronger collective advocacy for funding and policy support. Overall, a regional model strengthens system resilience by shifting from isolated agency operations to a coordinated, system-wide approach to emergency response.



What would your expectation for service look like from a regional effort for services to your constituency?

Answered: 20 Skipped: 24

RESPONSES

- 1 Fast response time.
- 2 All fire & ambulance services being trained properly and coordinated. Cost to be minimal so it does not put a strain on townships financials.
- 3 If people are paying, they expect prompt service.
- 4 Coverage of our township for 100% of the calls and in the timeliest fashion as able.
- 5 We would expect them to keep our local EMS intact due to response time and location
- 6 UNKNOWN
- 7 a Qualified medic on scene within 15 minutes of being dispatched
- 8 Headquartered in St Marys
- 9 Not discussed
- 10 A set number of staffed units strategically placed.
- 11 We are a rural community and have a very limited tax base. We cannot afford to pay for the coverage we currently have, but we do pay the agreed contracted amount.
- 12 100% dispatch / no missed calls / quality of care
- 13 I don't think the services would change for Pine Township. Response time would still be 15 to 30 minutes.
- 14 fair cost, good service, and well-trained personnel
- 15 Unsure but open to a discussion.
- 16 Similar to above, we would be concerned about response times if a single EMS service provided for the County.
- 17 Meet our current level of service
- 18 The same as we have now. A regional effort would not change service in our area but would possibly help keep it viable.
- 19 The best response time possible.
- 20 n/a

What governance structure would you expect for a regional EMS effort?

Answered: 21 Skipped: 23

RESPONSES

- 1 TBD
- 2 State
- 3 A council of all local fire & ambulance services. A board member from each department that votes on issues together as a group.
- 4 Not letting EMS agencies run and dictate
- 5 Perhaps a separate Board or Council comprised of representation from each municipality and EMS service within the "region".
- 6 There would need to be an elections
- 7 UNKNOWN
- 8 an active board with annual reporting and transparency
- 9 Board of Directors structure without political affiliations
- 10 Not discussed
- 11 Contractual
- 12 A regional board should be created providing all municipalities a "voice" on that board.
- 13 Association
- 14 I don't know.
- 15 Form a committee to oversee the regional EMS, each township or borough would need to have one representative on the committee
- 16 Unsure but open to a discussion.
- 17 That should be worked out between the EMS services, but representation from each area would be expected.
- 18 A board that contained equal representation for all parties involved.
- 19 A believe a board of directors much like they have now but with representation from the municipalities that they cover.
- 20 Medic services
- 21 n/a



What concerns would you have about regional EMS models?

Answered: 26 Skipped: 18

RESPONSES

- | | |
|---|--|
| <ul style="list-style-type: none">1 Unknown2 Cost3 Response time4 Not all municipalities would participate. They want free as much as possible.5 Unequal service coverage to certain areas within the region due to distance, road conditions, weather, etc. Too few ambulances and staffing to adequately cover a larger area.6 Physical location, time to respond7 Time, money8 Responding time and personal9 We'd be concerned that they would gear more to the more populated areas10 UNKNOWN11 Response times12 Too much efforts towards special interest or personal agenda versus community needs13 Residents not understanding the complexity or cost of the service14 Training requirements | <ul style="list-style-type: none">15 We would be required to pay more and raise taxes to cover the increased cost but would not receive better service than we currently do.16 Slower response times given the geographical area some regional models may cover.17 Cost18 Not enough employees.19 good service provided to each township or borough20 Unsure but open to a discussion.21 Difficulty covering such a large area with many remote locations.22 Increased response times and an equity in funding.23 The lack of concern and representation for the rural less populated areas.24 Sustainability in rural areas. We have varying governing structures that cannot always pay their share and therefore the cost goes up for the others.25 Where the station would be located. As of now medics are to close to the hospitals and need moved in more rural areas26 having sub-par coverage (sharing of resources) |
|---|--|

Most concerns about a regional EMS model focus on three main areas: cost, response times, and fairness. Many respondents worry that a regional system could increase costs for municipalities without clearly improving service, especially if taxes need to rise to support it. There is also concern that response times could become longer, particularly in rural areas where distance, terrain, and weather already create challenges.

Another common concern is whether all communities would receive equal service. Respondents noted the risk that more populated areas could receive priority, leaving rural areas underserved. Questions about participation, staffing shortages, and how costs would be shared also highlight uncertainty about how a regional system would work in practice. Overall, the feedback suggests interest in the concept, but a need for careful planning to ensure equitable, efficient service for all communities.



What trends or challenges do you foresee for EMS in your municipality over the next five to ten years?

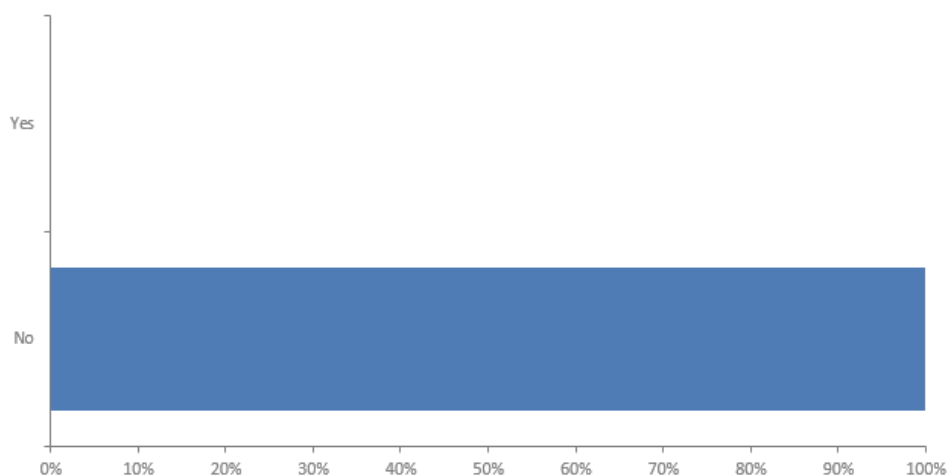
Answered: 28 Skipped: 16

RESPONSES

- | | |
|---|--|
| 1 Our Fire Department has a spending problem that they've been approached about. EMS is short handed. | 16 Financial stability and work force. |
| 2 None | 17 Lack of volunteers, lack of individuals going into the EMS field. |
| 3 It likely will worsen | 18 Volunteerism / Financial Condition |
| 4 Lack of volunteers . Increase in high risk recreation (ATV's). Increase in gas and oil traffic and logging truck activity. Decrease in residents to support the tax base. | 19 Outside EMS not having enough employees. |
| 5 Decrease in staffing, wages are too low, government needs to provide more support to rural ambulance services | 20 costing more, less providers |
| 6 Declining, hopefully it will still be here | 21 Ambulance services. |
| 7 Lack of personal | 22 A continued reduction in EMS workers. |
| 8 Funding | 23 Recruitment of new staff. |
| 9 UNKNOWN | 24 Recent changes made by our busiest service appears to have them in a solid place for the next 5-10 years. With the QRS service to ensure patient care during their busy times the multiple layers have patient care at a very high level. |
| 10 if nothing is done soon, I don't know how they can continue. | 25 Aging out of volunteers Lack of qualified personnel |
| 11 The financial challenges ahead | 26 Paid staffing |
| 12 Decreasing staffing. It is at an all-time low in all volunteers. | 27 We support regional EMS models because we are such a small Township. |
| 13 Responsibility for EMS being passed to the county. | 28 shortage of manpower |
| 14 Personnel numbers | |
| 15 Less people willing to volunteer. | |

Has your municipality ever participated in a busy study, heat-map, or predictive call location study for emergency medical services (QRS/EMS)?

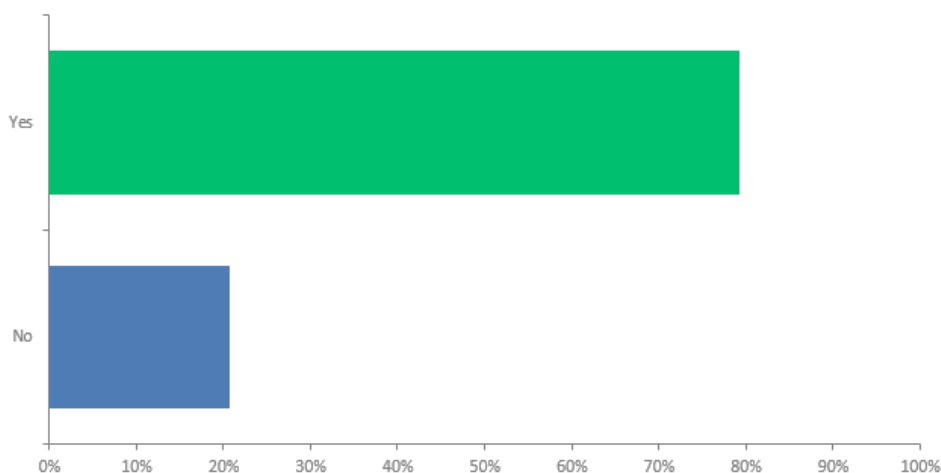
Answered: 38 Skipped: 6





Would your municipality consider adding EMS support to the agenda of any association meetings?

Answered: 29 Skipped: 15



Are there any other comments or information you would like to provide?

Answered: 16 Skipped: 28

RESPONSES

1 N/A

2 Emergency Medical Services across Pennsylvania—and across the nation—are facing a crisis that has been building for years. This is not the result of a single failure or a single agency. It is the cumulative impact of decisions, mandates, and expectations placed on EMS by the Department of Health, by elected officials, by municipalities, and even by the EMS system itself. The result is a model that is increasingly unsustainable for the providers who are expected to keep it running. The Department of Health continues to add requirements, certifications, and administrative obligations that far outpace the resources available to meet them. Training hours increase, documentation grows more complex, and compliance demands expand—yet funding, staffing, and reimbursement do not. The regulatory environment has become so heavy that many agencies struggle just to remain operational, let alone innovate or grow. EMS providers themselves are caught in an impossible position. They are expected to deliver care that approaches hospital-level complexity, but with training pipelines that are shrinking, wages that cannot compete with other industries, and workloads that continue to rise.



Are there any other comments or information you would like to provide?

Answered: 16 Skipped: 28

RESPONSES

2 Continued: Burnout is no longer an exception—it is the norm. Agencies are forced to rely on part-time staff, volunteers, or mandatory overtime simply to keep ambulances on the road. Municipalities and elected officials often rely on EMS as a critical public service while treating it as an optional one. Many communities still operate under outdated assumptions that EMS can function on donations, subscription drives, or reimbursement alone. The reality is that EMS is an essential service, but it is not funded like one. Without stable municipal support, agencies are left to absorb rising costs with no predictable revenue stream. The cost of operating an ambulance continues to climb—fuel, equipment, medications, training, insurance, and staffing all increase year after year. Meanwhile, reimbursement rates remain stagnant and often fail to cover even the basic cost of a transport. Agencies are expected to do more with less, and the math simply no longer works.

Are there any other comments or information you would like to provide?

Answered: 16 Skipped: 28

RESPONSES

2 Continued: The public wants what EMS has always provided: a timely response, safe transport to the hospital, and competent care along the way. They do not expect a “mobile emergency department” staffed with providers delivering physician-level interventions. Yet regulations and system design increasingly push EMS toward a level of care that is unrealistic, unfunded, and misaligned with what communities actually need. EMS is at a breaking point because the system around it has not kept pace with reality. The Department of Health sets requirements without providing resources. Providers are stretched beyond their limits. Municipalities rely on EMS but often fail to support it. Costs rise while reimbursement does not. And the public—through no fault of their own—still expects the reliable, transport focused service that EMS was originally built to provide. If EMS is to survive, the system must be rebuilt with honesty, sustainability, and shared responsibility. Communities deserve dependable emergency medical response, and providers deserve a system that supports them—not one that burdens them into collapse.



Are there any other comments or information you would like to provide?

3 This survey was completed by the township EMC with input from a supervisor.

4 N/A

5 no

6 No

7 No

8 Not at this time.

9 In completing this I am unsure what EMS is specifically, I at first saw it as the County Emergency Management System. But based on the question I gather it also was broader.

10 I am new to the township, so unable to answer some of these questions. Sorry

11 I think the premise behind this survey should have been shared with the local government agencies and EMS services before enlisting someone to conduct it.

12 When these studies are conducted, the rural areas cannot be pushed aside and lumped in with large municipal areas. Rural Pennsylvania has unique challenges that present different dynamics. Not all services are struggling and failing. The other component to this that nobody likes discuss is the lack of leadership in some of these small rural services. The poor leadership is displayed by the poor delivery of services.

13 Difficult problem due to declining population and skyrocketing costs. Our rural area needs this conversation.

14 This area is in desperate need of help for a higher level to help both EMS and fire for rural areas.

15 Elk County EMS providers work well together to provide services



Key Findings

Compensation – Funding – Sustainability

A total of fifteen EMS agencies were interviewed in Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties. Service types included volunteer fire department run EMS, stand-alone volunteer EMS, hybrid, or combination agencies, and paid services with full-time, part-time, and administrative staff. Operating budgets for these services range from five to seven figures with most agencies operating in a deficit. Billing is the primary source of revenue with additional revenue sources including grants, membership drives, fundraising, stipends, municipal contributions, and donations. The secondary sources of revenue above are used to cover deficits as possible.

In-kind support is offered by some municipalities in the form of supplies, service, or insurance. Several municipalities, when asked, indicated that they do not provide in-kind services but would if asked by an agency.

Salaries are comparable across the region, with few employees reported as leaving one service to work for another EMS or medical agency. Paramedic starting salaries range between \$18.50 and \$25.00/hour, EMT-A between \$17.00 and \$21.00, and EMT between \$12.00 and \$21.00. The greatest scale differential is EMT, followed by paramedic. The average hourly rate for a paramedic in Pennsylvania is \$22.28 to \$25.00. The average hourly rate for an EMT in Pennsylvania is \$20.45 to \$22.94. Rates in the six-county study region average moderately to slightly lower than the state average.

Benefit programs for paid agencies are similar across the region with most paying 100% premium for health, dental and vision insurance, offering a 3% match retirement benefit, paid time-off, flexible scheduling, and paid sick time. These benefit programs align with the typical EMS agency benefit programs in Pennsylvania.

Most volunteer organizations provide incentives including stipends, training, and gear to volunteers.

Nearly all agencies, both paid and volunteer, indicated billing for service as the primary source of revenue. However, billing revenue is not sufficient to sustain any of the reporting agencies. Additionally, all agencies indicated that their payer mix was primarily Medicare and Medicaid. Billing for the agencies in this region is completed both in-house and through third-party vendors. The percentage of actual billed revenue collected ranges from 33 to 90 percent. This differential indicates that shared best practices for billing would benefit all EMS agencies in the



region. Billing and coding education, shared billing service, municipal support for billing, and billing for services which don't conclude in transport are potential methods for increasing revenue collected. Several agencies indicated that they receive a high rate of return from their third-party billing vendor. Cooperative agreements with multiple agencies could benefit the services already using a biller by decreasing rates, while services not using a biller could potentially achieve a higher rate of return by working with a third-party biller.

Through both agency interviews and survey response it became evident that while most agencies have at least one administrative person, that person does not always have business experience. Reported cost per unit hour ranged from \$33.00 to \$800.00, indicating that the metric is not equally measured service to service. Additionally, looking at annual budgets, few services indicated that their budget was sufficient, or if it was, it was not calculated based on revenue, so either way nearly every agency is operating in a deficit. While some agencies indicated that they have reserve funds, these reserves cannot sustain indefinitely. Whether non-profit, not-for-profit, or for-profit, services with the greatest opportunity for success are managed as a business. Long-term planning, investment, capital purchase planning, and accounting for depreciation. Shared best practices among services could benefit services without an experienced business manager. Volunteer organizations could recruit a volunteer with business management experience to assist. This is also an area where municipalities or counties could offer in-kind support by offering financial planning assistance.

Additional revenue sources include membership/subscription programs, grants, donations, and municipal support ranging from small donations to tax millage. Some agencies have robust grant programs and are able to secure significant grant funding. This is an area in which shared best practices, and support from municipal or county grant writers could benefit agencies who have not yet built a robust grant program.

Grant programs available to Pennsylvania EMS agencies include the below:

Fire Company and Emergency Medical Services Grant (FCEMSGP)

- Administered by the Office of the State Fire Commissioner
- Funds
- Facilities
 - Equipment
 - Debt reduction
 - Training and certification
 - Public education
 - Overtime and backfill for career agencies



- Recruitment and retention programs
- Construction savings account for new facilities

USDA Rural Development Grants:

- Administered by the USDA
- New buildings
- Apparatus and equipment
- Community facilities programs

Community Foundation and Industry Grants:

- Business and industry often offer grants to community service organizations
 - Some national businesses include
 - State Farm
 - Lowe's
 - Firehouse Subs
 - County or municipal philanthropic organizations

Local Skills Game Revenue:

- One municipality indicated discussion on using skills game revenue to support EMS.
- In Pennsylvania, skills games operate in a legal “gray” area in regard to taxation.
- Businesses operating skills games may, and sometimes do, use some proceeds for donations to community service organizations.
- Potential lobbying area to require taxation on skills games in Pennsylvania with intent to direct to EMS. This could be expanded to include a portion of lottery proceeds as well, however, currently Pennsylvania lottery proceeds benefit older Pennsylvanians.

Additional grant information and tips for writing successful grants can be found in the Pennsylvania First Responders Funding and Resource Guide, GrantWatch, and Grants.Gov.

A variety of sustainable funding models are being used both within the study region and across the country. There is no one-size-fits-all funding model, however many agencies have found success with one or more of those identified below.

- Public-Private Partnerships – Agencies collaborate with private sector to co-fund infrastructure, technology, shared space, or services.
- Private investments/Corporate sponsorship – Similar to the above, agencies seek private investors or corporate sponsorships for education, equipment, or building space.



- Insurance and Reimbursement – Billing for service was indicated as the primary revenue source for all interviewed EMS agencies. Continued lobbying is needed for increased reimbursement levels, and direct reimbursement to the agency instead of the insured.
- Government Funding - Many municipalities and counties are adding an EMS tax to provide funding. In 2024 the max EMS tax rate was raised from 0.5 mills to 5 mills. Municipalities are often hesitant to raise taxes; however, citizens are often willing to pass a referendum for an EMS tax if they are aware of the need.

Another potential tool for financial sustainability could be shared staffing. Many agencies indicated that overtime pay is a budgetary strain, with several indicating that shared staffing could help relieve the strain. Many agencies, both paid and volunteer also indicated that members worked and/or volunteered with additional agencies. A cooperative agreement between agencies for shared staffing could benefit all agencies throughout the region and limit overtime pay in the budget.

Pennsylvania Rural Health Transformation Plan (RHTP) Funding:

Recently, The Pennsylvania Rural Health Transformation Plan announced the availability of \$25 million dollars to EMS and healthcare in rural Pennsylvania.

The Pennsylvania Rural Health Transformation Plan (RHTP), administered by the Department of Human Services, represents a significant statewide investment in strengthening rural healthcare delivery systems. The program is designed to stabilize, modernize, and expand access to healthcare services across rural communities through targeted funding initiatives. The current funding opportunity under the “Rapid Response Stabilization Program” is available to qualifying entities, with individual awards ranging from \$10,000.00 to \$1,000,000.00.

The intent of this initial funding round is to provide near-term financial support to healthcare providers and systems that can demonstrate an immediate need to stabilize or enhance service delivery. Funding must align with one of six priority areas identified in the federally approved RHTP framework: aging and access, behavioral health, emergency medical services (EMS) and transportation, maternal health, technology and infrastructure, and workforce development.

For rural EMS agencies and systems, the inclusion of “EMS and Transportation” as a dedicated priority area confirms the Commonwealth’s recognition of EMS as a critical component of the rural healthcare continuum.

Eligible Uses of Funding for EMS:



The RHTP funding opportunity provides relatively flexible funding for capital and operational stabilization investments, making it particularly relevant to EMS agencies that often face chronic funding constraints. Eligible uses of funds include expenditures on supplies, equipment, and facility-related improvements, provided that the investments directly support improved access to rural healthcare services.

For EMS organizations, allowable applications of funding may reasonably include:

Equipment and Operational Capacity:

Funding may be used to procure essential EMS equipment necessary to sustain or enhance response capabilities. This could include ambulances, cardiac monitors, stretchers, communication systems, or other mission-critical tools that directly impact patient care and response readiness. These types of investments are especially important in rural areas where aging equipment and limited capital budgets often constrain service delivery.

Facility Renovation and Infrastructure Improvements:

RHTP funds may also support renovations or structural improvements to EMS stations or facilities. This could involve expanding station capacity, improving crew quarters, upgrading maintenance areas, or addressing code compliance issues. For rural EMS agencies operating in outdated or undersized facilities, these investments can significantly improve workforce retention and operational efficiency.

System Stabilization Initiatives:

Importantly, the funding is not limited to discrete purchases but may also be used to stabilize broader EMS system operations. This could include initiatives designed to prevent service reductions, maintain adequate staffing levels, or sustain service coverage in underserved areas. The emphasis on “stabilization” recognizes the financial fragility of many rural EMS providers.

Integration with Broader Healthcare Delivery:

Because the funding must enhance rural healthcare access, EMS agencies are well-positioned to propose projects that integrate with hospitals, clinics, or public health efforts. Investments that improve patient transport reliability, reduce wait times, or enhance coordination with healthcare partners are likely to align strongly with program goals.

Future EMS-Focused Funding Opportunities:

While the current Rapid Response Stabilization Program provides immediate funding for basic needs, the RHTP framework also signals a broader, longer-term transformation strategy that is



particularly promising for EMS systems. Planned future funding rounds include several EMS-specific program areas, such as rural EMS sustainability initiatives, community paramedicine programs, and mobile integrated healthcare (MIH) models.

These future opportunities are expected to support:

- Development of community paramedicine and mobile health programs
- Expansion of non-emergency medical transportation services
- Implementation of innovative service delivery models targeting high-risk populations
- Workforce development and training initiatives specific to EMS

For counties or regions seeking to modernize EMS delivery, particularly through community paramedicine or integrated healthcare approaches, these anticipated funding streams represent a critical opportunity for strategic transformation beyond basic stabilization.

Application Process:

The application process for the current RHTP funding round is designed to be streamlined, focusing on eligibility verification and clear alignment with program goals. Eligible applicants include hospitals, healthcare providers, and rural health facilities operating within designated rural regions.

To apply, entities must complete and submit an eligibility certification along with supporting budget documentation. Required materials include a budget narrative explaining how funds will be used and a budget worksheet detailing projected expenditures.

Unlike traditional grant competitions that rely heavily on scoring and ranking, this program functions more as a capped funding pool. Applications are reviewed for eligibility and alignment, and funds are distributed until the available allocation is exhausted. As a result, timeliness of submission is a critical factor in securing funding.

Applicants must clearly demonstrate that their proposed project:

- Supports rural healthcare access or stabilization
- Aligns with one of the designated RHTP initiative areas
- Represents an appropriate and justifiable use of public funds

For EMS agencies, this means framing requests not only in terms of organizational need but also in terms of measurable impact on patient care access and system reliability.

Application Timeline and Considerations



This year, the application window for the current funding opportunity opened on May 1, 2026, and is closed on June 1, 2026. However, the program includes a key condition: applications will only be accepted until the total funding cap is reached, which may occur before the formal closing date.

This structure effectively creates a rolling or first-come, first-served dynamic, placing a premium on early submission. EMS agencies and partnering organizations should be prepared to act quickly, with project scopes, budgets, and supporting documentation developed in advance of the application opening date.

Strategic Implications for EMS Systems:

The RHTP funding opportunity presents both immediate and long-term strategic implications for EMS systems in rural Pennsylvania. In the short term, it offers a rare opportunity to address long-standing capital and infrastructure deficiencies that can undermine service delivery. Agencies that pursue funding for equipment replacement, facility upgrades, or stabilization initiatives can achieve meaningful operational improvements with relatively limited administrative burden.

In the longer term, the RHTP framework signals a shift toward integrated, outcomes-driven rural healthcare systems in which EMS plays a more central role. The explicit inclusion of community paramedicine, mobile health, and transportation innovation in future funding rounds suggests that EMS providers will increasingly be viewed not only as emergency responders but also as essential healthcare access points.

For rural counties, this creates an opportunity to align EMS system planning with broader healthcare transformation goals. Agencies and local governments should consider how current funding requests can serve as foundational investments that position them for future innovation funding. For example, upgrading technology infrastructure or expanding workforce capacity today may enable participation in community paramedicine or mobile health initiatives in subsequent funding cycles.

The Pennsylvania RHTP funding opportunity represents a significant and timely investment in rural healthcare infrastructure, with clear and meaningful implications for EMS providers. By allowing funding for equipment, facilities, and system stabilization, the program directly addresses many of the structural challenges facing rural EMS agencies.

At the same time, the broader RHTP framework points toward a future in which EMS is more deeply integrated into the healthcare system through innovative service models and expanded roles. Agencies that take advantage of the current funding opportunity, while also planning for



future program phases, will be best positioned to strengthen both their operational sustainability and their role within the evolving rural healthcare landscape.

There are a number of funding models, grant programs, in-kind services, county and municipal support, areas for lobbying, and other forms of assistance that can serve EMS agencies. The variation in demographics, including population size and type, distance from hospital/trauma centers, attraction to younger adults, and taxation do not allow for a one-size-fits-all solution. Agencies, municipalities, and counties need to work together to determine the best fit for their area, considering the pros and cons of regionalization, consolidation, county-wide/regional systems, and what can be done in-kind to support EMS. Additionally, financial and administrative education and experience for service managers, and municipal or county assistance with expertise could greatly enhance sustainability.

Implications of the Closure of Bradford Regional Medical Center on Emergency Medical Services and Regional Healthcare Operations

The recent closure of Bradford Regional Medical Center (BRMC) represents a significant inflection point for emergency medical services (EMS), healthcare access, and regional system stability across the northern tier of Pennsylvania and adjacent areas of New York. As depicted in the regional receiving-facility map, BRMC previously served as a critical anchor institution within the network of hospitals supporting McKean County and surrounding areas. Its geographic position, centrally located among rural communities with limited alternative healthcare infrastructure, made it a vital component of the emergency care continuum.

The loss of BRMC introduces a cascade of operational, clinical, financial, and logistical impacts. These effects extend beyond the immediate community of Bradford and influence EMS agencies, municipal governments, healthcare systems, and residents across multiple counties. This section examines the full spectrum of consequences associated with the closure, including risks, opportunities, and system-level considerations for EMS planning.

Geographic and System Context

BRMC historically functioned as one of the few receiving facilities within a large, predominantly rural service area. The map of receiving facilities illustrates the distribution of hospitals across the region, with BRMC positioned strategically between Olean General Hospital to the north, UPMC Kane to the south, and UPMC Cole to the east. The 15-mile service buffers around each facility highlights the sparse coverage and significant distances between hospitals.

In this environment, BRMC's closure removes a key node in the emergency care network. The resulting geographic gap increases transport distances for EMS units and shifts patient volume to



neighboring hospitals potentially already operating within constrained rural healthcare environments.

Increased Primary Transport Distances:

With BRMC no longer available, EMS agencies must transport patients to alternative facilities such as:

- Olean General Hospital
- UPMC Kane
- UPMC Cole
- Penn Highlands Elk

Depending on the patient's location, these diversions can add significant time to transport times even in optimal weather and road conditions. In rural EMS systems, where baseline transport times are already lengthy, even modest increases can have substantial operational and clinical consequences. For example, a patient transported from the City of Bradford now requires significantly longer travel times to reach any receiving facility: Bradford to Olean General adds approximately twenty-six minutes; Bradford to UPMC Kane adds forty minutes; Bradford to UPMC Cole adds one hour and three minutes; and Bradford to Penn Highlands Elk adds one hour and five minutes. What was once a thirty-minute cycle, transport, handoff, and return to service, has now quadrupled. This dramatically increases unit downtime and places substantial strain on surrounding EMS agencies that must absorb additional call volume. And this reflects only a single agency's experience.

Extended Out-of-Service Time for EMS Units:

Longer transports directly translate into longer periods during which EMS units are unavailable for additional calls. This effect compounds in several ways:

- Reduced unit availability during peak call periods
- Increased reliance on mutual aid, often from agencies facing similar staffing and resource constraints
- Longer response times for subsequent emergencies
- Higher operational costs, including fuel, vehicle wear, and personnel hours

For agencies already struggling with staffing shortages, these extended out of service intervals exacerbate system fragility.

Increased Likelihood of System Saturation:



In rural EMS systems, it is common for agencies to operate with one or two staffed ambulances. When a single transport requires an hour or more of travel time, the community may be left without immediate EMS coverage. The closure of BRMC increases the frequency of these coverage gaps, raising the risk of delayed care for time sensitive emergencies such as cardiac arrest, stroke, trauma, and high acuity scenarios.

Clinical Implications for Patient Care:

Increased transport times have a direct and measurable effect on patient outcomes, particularly in rural regions where baseline distances are already substantial. When a nearby receiving facility closes, every emergency, whether medical, traumatic, or behavioral, begins with a longer interval before definitive care is reached. For time sensitive conditions such as stroke, STEMI, major trauma, and respiratory failure, these added minutes are not simply inconvenient; they represent lost opportunities for early intervention. Stroke patients may fall outside the treatment window. Cardiac patients may exceed recommended treatment benchmarks, increasing myocardial damage and long-term morbidity. Trauma patients, already at higher risk in rural settings, face prolonged exposure to hemorrhage, hypoxia, or shock before surgical care is available. Even lower acuity patients experience prolonged discomfort, delayed diagnostics, and increased risk of deterioration during transport.

These clinical risks are compounded by the operational realities of rural EMS. Longer transports mean EMS crews must manage critically ill patients for extended periods, often without the benefit of rapid backup or advanced interventions available in urban systems. Providers must maintain airway control, hemodynamic stability, and continuous monitoring over distances that may exceed 30–60 minutes. This increases the likelihood of enroute complications and places significant cognitive and physical demands on EMS personnel. The longer a patient remains in the prehospital environment, the greater the chance that subtle changes in condition, worsening mental status, arrhythmias, respiratory fatigue, will occur before hospital resources can intervene. In short, increased transport times shift more of the clinical burden onto EMS providers while simultaneously delaying the definitive care that improves survival and recovery.

Potential Increase in on-Scene Interventions:

Providers may need to stabilize patients more aggressively before transport, knowing that the nearest receiving facility is significantly farther away. This can increase scene times and further delay definitive care.



Staffing Strain and Burnout:

Staffing strain and burnout intensify quickly when transport times increase, because every extended call pulls EMS personnel away from their home district for longer periods and forces them to operate at a sustained high tempo. Longer transports mean crews spend more time managing patients in the back of the ambulance, navigating rural road networks, and completing extended handoff and turnaround processes at distant hospitals. This prolonged operational cycle elevates fatigue levels, especially during overnight shifts or periods of high call volume. Fatigue erodes clinical performance, slows decision making, and increases the risk of errors, all while placing additional emotional and physical stress on providers. Over time, this constant pressure diminishes morale, contributes to compassion fatigue, and accelerates burnout, an already significant challenge in rural EMS systems where staffing pools are limited and workloads are unevenly distributed.

These pressures also make it harder for agencies to retain personnel, particularly volunteers and part time providers who balance EMS duties with full time employment or family responsibilities. When a single call can consume two to three hours due to extended transport and turnaround times, the burden becomes unsustainable for many. Agencies relying on per-diem or part-time staff face increasing scheduling challenges, as fewer providers are willing or able to commit to long shifts that may involve prolonged out of service periods. This creates a feedback loop: staffing shortages lead to more mandatory overtime or increased reliance on a shrinking pool of responders, which further accelerates burnout. Ultimately, the closure of a nearby hospital doesn't just lengthen transports—it destabilizes the human infrastructure of EMS, placing the entire system at risk of chronic understaffing and reduced readiness.

Financial Impacts:

Financial impacts from longer transports accumulate quickly for EMS agencies, especially those already operating on thin margins. Every additional mile traveled increases fuel consumption, accelerating vehicle wear. Rural ambulances often operate on challenging terrain, so extended transports amplify maintenance needs and raise the likelihood of mechanical failures. These costs are not easily absorbed by small agencies whose budgets rely heavily on already thin budgets, fundraisers, municipal subsidies, modest reimbursement rates, and unpredictable call volumes. At the same time, longer call durations translate directly into higher personnel costs. Crews remain committed to a single incident for significantly longer periods, increasing overtime, extending shift lengths, and reducing the number of calls an agency can bill for during a given period. For agencies that pay stipends or hourly wages to part-time or per-diem staff,



these extended transports can dramatically increase payroll expenses without a corresponding increase in revenue.

Compounding these pressures is the growing risk of uncompensated care. As transport distances increase, some patients, particularly those with chronic conditions or limited financial resources, may decline transport altogether due to concerns about cost, travel time, or the burden placed on family members. When patients refuse transport after EMS assessment and treatment, agencies often receive little or no reimbursement for the care provided on scene. This trend erodes financial stability and places additional strain on agencies already struggling to cover rising operational costs. Over time, the combination of higher expenses, stagnant reimbursement rates, and increased rates of non-transport encounters can push smaller EMS organizations toward fiscal distress, forcing municipalities to consider consolidation, increased subsidies, or alternative service delivery models simply to maintain basic emergency coverage.

Mutual Aid and Regional Dependencies:

The closure increases reliance on mutual aid agreements. However:

- Neighboring agencies face similar staffing shortages
- Mutual aid units may also face extended transports
- System-wide strain increases the likelihood of simultaneous coverage gaps

This creates a regional vulnerability where multiple communities may be left without timely EMS response.

Impacts on Remaining Receiving Facilities:

Hospitals such as Olean General, UPMC Kane, and UPMC Cole will absorb the patient load previously handled by BRMC. This may result in:

- Longer emergency department wait times
- Increased hallway boarding
- Strain on inpatient bed availability
- Increased demand for specialty services

As EDs become saturated, facilities may declare diversion more frequently. This forces EMS agencies to transport patients even farther, compounding the challenges described above.



Strain on Specialty Care Networks

BRMC's closure may shift demand for:

- Cardiology
- Orthopedics
- General surgery
- Behavioral health

If neighboring hospitals lack capacity or specialty coverage, patients may require transfer to tertiary centers, adding additional transport time and EMS involvement.

Residents of Bradford and surrounding communities lose immediate access to previously available services such as emergency care, inpatient services, diagnostic imaging, outpatient specialty care, and other services. This may lead to delayed care-seeking behavior and increased reliance on EMS for non-emergent conditions.

Hospital closures almost always create a ripple effect that extends far beyond the loss of emergency and inpatient services, and one of the most immediate consequences is a measurable increase in EMS utilization for conditions that traditionally fall within the realm of primary care. When a community loses its local hospital, residents often have fewer options for timely outpatient care, urgent care, or chronic disease management. As a result, EMS becomes the default access point for individuals experiencing low-acuity issues such as minor infections, medication refills, or unmanaged chronic conditions. This shift leads to more 911 calls for non-emergent needs and increases the frequency of EMS responses for illnesses that previously might have been managed through routine clinical visits. Additionally, with fewer facilities available to accept patients, interfacility transfers become more common and more time-consuming, further straining EMS resources and reducing system capacity.

The economic and social impacts of a hospital closure compound these clinical and operational challenges. Hospitals are often among the largest employers in rural communities, and their closure can destabilize the local economy, increase unemployment, and reduce household income levels. These economic stressors can worsen health disparities, increase reliance on public services, and elevate EMS call volume as more residents delay care until conditions become significant or unmanageable. At the same time, the loss of a hospital erodes community confidence in the local healthcare system. Residents may perceive that emergency care is less accessible or less reliable, leading to increased anxiety and a greater tendency to call 911 for reassurance or evaluation. Over time, these factors place additional pressure on EMS agencies,



threatening long-term sustainability and forcing municipalities to confront difficult decisions about funding, staffing, and service delivery models.

The closure of a regional hospital such as Bradford Regional Medical Center creates undeniable strain on EMS operations, but it also opens the door for meaningful system redesign and modernization. One of the most immediate opportunities lies in strengthening regional EMS coordination. Agencies that once operated independently may now find value in enhanced mutual-aid agreements, shared staffing pools, and coordinated deployment strategies that treat EMS resources as a regional asset rather than isolated municipal units. Shared scheduling platforms and regionalized staffing models can help distribute workload more evenly, reduce burnout, and ensure that at least one or two ALS units remain available within a given geographic zone even during long-distance transports. These collaborative approaches not only improve operational resilience but also create a more predictable and sustainable EMS environment across county lines.

At the same time, the increased strain on emergency departments and the rise in low-acuity 911 calls create a compelling case for expanding community paramedicine programs. By managing chronic conditions in the home, conducting post-discharge follow-ups, and addressing gaps in primary care access, community paramedics can significantly reduce unnecessary transports and preserve EMS availability for true emergencies.

Telemedicine integration further amplifies this benefit. Real-time physician consultation during long transports, remote monitoring, and early activation of receiving-facility resources can improve patient outcomes and reduce on-scene decision-making pressure for EMS crews. These tools effectively extend the reach of rural healthcare systems.

The hospital closure may also prompt health systems to rethink how specialty services are distributed across the region. Consolidating specialty care at strategically located facilities, improving interfacility transfer protocols, and investing in critical access hospitals can stabilize the broader healthcare network. Meanwhile, EMS agencies can adopt data-driven deployment models, such as predictive analytics, dynamic posting, and real-time resource monitoring, to mitigate the impact of longer transports on response times. These strategies help ensure that ambulances are positioned where they are most likely to be needed, improving coverage despite increased operational demands.

Taken together, these opportunities represent a pathway toward a more integrated, resilient, and technologically supported EMS system. While the closure of a hospital introduces significant risks, including increased response times, higher mortality for time-sensitive emergencies, ED overcrowding, and staffing burnout, it also creates the impetus for regional innovation. By



reevaluating response-time standards, strengthening interfacility transfer capabilities, implementing tiered response models, and investing in training for prolonged field care, EMS planners can transform a destabilizing event into a catalyst for long-term system improvement.

The closure of Bradford Regional Medical Center represents a profound shift in the regional healthcare landscape. Its absence creates longer transport times, increased EMS out-of-service intervals, heightened operational strain, and significant clinical risks for patients. Neighboring receiving facilities will experience increased demand, potentially leading to overcrowding and diversion.

However, the situation also presents opportunities for modernization, regional collaboration, and innovation in EMS delivery. By proactively addressing the challenges and leveraging available opportunities, regional stakeholders can strengthen the resilience and effectiveness of the emergency medical services system.

This analysis should serve as a foundation for strategic planning, policy development, and coordinated action among EMS agencies, healthcare systems, municipal leaders, and regional partners.

Recruitment and Retention

Emergency Medical Services (EMS) agencies across the United States are experiencing extraordinary strain in recruiting and retaining qualified personnel. The NFPA reports that the U.S. volunteer fire service has lost nearly a quarter of its members since 2008, dropping from about 827,000 to 635,000 by 2023. Call volumes have risen about 70% in the same period, leaving remaining volunteers under immense strain. What was once a system sustained by a robust volunteer base and a steady pipeline of new EMTs and paramedics has shifted into a landscape defined by workforce shortages, rising operational demands, and increasing burnout. These pressures are not isolated to any single region; they represent a nationwide crisis affecting rural, suburban, and urban EMS systems alike. The diminishing volunteer base, historically the backbone of EMS in many communities, has accelerated the urgency of addressing systemic workforce challenges. As EMS agencies struggle to maintain adequate staffing levels, the reliability and resilience of emergency medical response are increasingly at risk.

The decline in volunteerism is one of the most significant contributors to the current workforce shortage. For decades, volunteer EMS agencies provided essential coverage in rural and semi-rural communities where call volumes were low and municipal budgets limited. However, changes in society have dramatically reduced the availability of individuals able to volunteer. Dual-income households, longer commutes, increased family obligations, and shifting cultural



expectations have all contributed to fewer people having the time or flexibility to commit to EMS training and service. Additionally, the training requirements for EMTs and paramedics have expanded over time, increasing the time commitment needed to become certified. In rural Pennsylvania, specifically the region studied, many of the agencies expressed concerns over the distances potential EMT candidates must travel to attend training, exacerbating the time commitment needed. While these enhancements have improved clinical quality, they have also created barriers for individuals who might otherwise have volunteered. As a result, many communities that once relied on volunteers now face gaps in coverage, increased response times, and escalating pressure to transition toward paid or at the very least, hybrid staffing models.

Compounding the decline in volunteerism is the broader national workforce shortage affecting all levels of EMS. Recruitment has become increasingly difficult as EMS competes with other industries offering higher wages, more predictable schedules, and less emotionally taxing work environments. The physical and psychological demands of EMS combined with modest compensation in many regions make it challenging to attract new entrants to the field. Younger generations, in particular, often seek career paths with clearer advancement opportunities and better work-life balance than traditional EMS roles provide. Even when individuals do enter EMS, many do not remain long-term. High turnover rates are common, especially among new EMTs who often view the role as a steppingstone to other healthcare professions such as nursing, firefighting, or physician assistant programs. Across the region studied, there is a clear and ongoing population decline that closely tracks with the loss of stable employment opportunities. Many interview participants emphasized that younger residents no longer see viable long-term careers in the area, which directly affects the pool of people who might otherwise volunteer with local EMS agencies. Even for individuals who are interested in pursuing EMS as a career, the lack of complementary job opportunities for their partners or spouses makes it difficult for families to remain in the region. As a result, EMS agencies already struggling to fill essential roles face an even smaller and shrinking workforce. This combination of economic contraction and limited career pathways has created a cycle in which fewer residents are available or able to volunteer or work in EMS, further straining agencies that depend heavily on local participation to remain operational. Retention challenges are further impaired by the increasing complexity and intensity of EMS work. Call volumes have risen steadily nationwide, driven by factors such as aging populations as illustrated in the background and introduction section of this report, increased chronic disease prevalence, behavioral health crises, and the closure of rural hospitals, such as Bradford Regional Medical Center. Longer transport distances especially in rural areas where hospital consolidation has reduced local access to emergency care extend the time crews spend out of service. These extended call durations contribute to fatigue, burnout, and reduced morale. Agencies report that providers are leaving the profession not only because of



compensation issues but also because of the cumulative emotional toll of the work. Exposure to traumatic incidents, staffing shortages that force excessive overtime, and the pressure of maintaining high clinical performance standards all contribute to a workforce that feels increasingly strained.

Training and certification barriers also play a significant role in recruitment and retention difficulties. The National Registry of Emergency Medical Technicians (NREMT) certification process, while essential for ensuring national standards, has been widely cited as a challenge for new EMT candidates. Many students report struggling with the didactic portion of the curriculum, particularly the written exam, which may not always align with the instructional time or teaching methods available in local courses. An exception to this should be noted when referencing the NPREC training and their outstanding initiatives to ensure the success of all students. When candidates fail the exam, the discouragement combined with the time and financial investment required to retake the course may lead them to abandon the certification process entirely. This bottleneck reduces the number of new EMTs entering the workforce and places additional strain on agencies already struggling to fill shifts. In some regions, limited access to training programs further restricts the pipeline of new providers, especially in rural areas where educational resources are scarce.

Retention is also hindered by the lack of competitive compensation and benefits in many EMS systems. While some agencies have increased wages in response to staffing shortages, EMS salaries often remain lower than those offered by competing healthcare and public safety fields.

“Until we are seen as part of the overall healthcare system, we will continue to struggle as EMS providers.”

Interview Participant

Paramedics, in particular, face a significant wage gap compared to nurses, despite having similar levels of responsibility and clinical decision-making. This disparity encourages experienced providers to leave EMS for more financially stable and less physically demanding careers. Additionally, many EMS agencies, especially volunteer and smaller services, struggle to offer benefits such as health insurance, retirement plans, or paid time off, further reducing their ability to retain staff.



The nationwide shortage of EMS personnel has also intensified competition among agencies. Larger or better-funded organizations can offer higher wages, sign-on bonuses, and more attractive schedules, drawing providers away from smaller or rural agencies. This creates a cascading effect: as smaller agencies lose staff, remaining personnel face increased workloads, which accelerates burnout and turnover. In some areas of the U.S., agencies have been forced to reduce service hours, rely heavily on mutual aid, or consider consolidation as a means of survival. The loss of local EMS coverage can have profound impacts on community safety, particularly in areas where response times are already lengthy due to geography or limited resources.

Despite these challenges, many EMS systems are exploring innovative strategies to improve recruitment and retention. Workforce development initiatives such as sponsoring EMT training, offering tuition reimbursement, and creating career ladders, have shown promise in attracting new providers. Some agencies are partnering with high schools, community colleges, and workforce development boards to introduce EMS career pathways earlier and reduce financial barriers to entry. Others are implementing mentorship programs, mental health support services, and flexible scheduling models to improve retention and reduce burnout. Regional collaboration, including shared staffing pools and consolidated administrative functions, is also emerging as a strategy to stabilize coverage and reduce operational strain.

Regional workforce resources can further support EMS agencies in expanding their recruitment efforts. Workforce Solutions for North Central PA and the PA CareerLink system can assist EMS employers with recruitment services, including job postings, candidate screenings and referrals, hiring events, career fairs, targeted recruitment activities, and labor market information. Coordinating recruitment efforts through the workforce system can help EMS agencies increase the visibility of available positions, reach a broader pool of potential candidates, and connect interested individuals with EMS training and career pathways. PA CareerLink can also help individuals explore and pursue EMS employment opportunities through career planning, skills assessments, job search and placement assistance, and connections to education and occupational training. For eligible participants, supportive services may also be available to help address barriers that could interfere with successful participation in training or employment. Together, these resources can help individuals move from interest in an EMS career to training, employment, and longer-term career advancement.

Addressing the nationwide EMS workforce crisis will require coordinated action at the local, state, and federal levels. Sustainable funding models are essential to support competitive wages, training programs, and the transition from volunteer-based to hybrid or fully paid staffing structures where necessary. Regulatory bodies may need to evaluate certification processes to



ensure they maintain high standards while remaining accessible and aligned with real-world instructional capacity. Communities must also recognize the critical role EMS plays in public safety and healthcare, advocating for policies and investments that strengthen the workforce and ensure reliable emergency response.

The diminishing volunteer base and the broader recruitment and retention challenges facing EMS represent a pivotal moment for the profession. Without meaningful intervention, many communities' risk further degradation of emergency medical response capabilities. However, with strategic planning, investment in workforce development, and a commitment to modernizing EMS systems, it is possible to build a more resilient and sustainable future. The path forward requires acknowledging the depth of the crisis, understanding its root causes, and implementing solutions that support the dedicated individuals who provide lifesaving care every day.

Workforce Solutions for North Central PA's PA Six Career Platform provides an existing regional resource to support EMS career awareness and recruitment. The platform can be used to increase the visibility of EMS employers and occupations, provide information about career pathways and education and training requirements, and connect students' job seekers, career changers, educators, and parents with EMS career opportunities in the region.

EMS agencies should be encouraged to participate in PA Six Careers and other business education activities that provide opportunities for career presentations, demonstrations, job shadows, career fairs, and other experiences that expose individuals to EMS careers and create a pipeline into future training and employment.

Training and Certification

Background of Training and Certification Concerns

Across the region studied (Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties), as well as throughout the Commonwealth of Pennsylvania, and the broader United States there is a well-documented and growing shortage of first responders. The region has partnered with Workforce Solutions and other local stakeholders to find ways to not only encourage individuals to become first responders, but to also work together on training and certification gaps, recruitment pipelines, and workforce sustainability.

Within Pennsylvania most areas are served by volunteers instead of career personnel, which increases response time due to volunteer availability. While this model has traditionally served communities well, it introduces operational challenges particularly related to responder availability during daytime hours and other peak demand periods. Volunteers provide their time



to emergency medical services separately from their time commitments to family, society, and careers. The number of responders in general has decreased, in part due to issues including:

- Funding limitations
- Retention challenges
- Increased training and certification requirements
- Competing personal and professional obligations

As a result, there are fewer volunteers performing the tasks associated with fire, medical, and rescue operations, creating a negative effect on a service's ability to respond to emergencies in a timely manner.

Additionally, obligations related to time commitments and expenses required for training are potential factors in the decline of first responders. The initial training time for emergency medical services (EMS) can take several months to complete and emergency medical services personnel are required to maintain a regular and ongoing schedule of continued education as a component of their certification maintenance.

There are additional challenges for individuals who volunteer, including the dedication of time beyond their current employment, family and social commitments, and community obligations that must be dedicated to training, responding, and fundraising. Training is essential to provide for the general knowledge and safety of volunteers. Collaborative training implementation is needed in the region to help develop and sustain a comprehensive EMS system.

Training and Certification Improvements

Addressing workforce challenges requires a coordinated, regional approach to EMS education. Strengthening training through collaboration with existing educational institutions and training providers represents a key opportunity to enhance EMS readiness. Additionally, the regional agency could host regular in-service and continuing educational training sessions for staff and volunteers, as well as the public. Classes provided to the public could improve patient care, reduce access times, and could also serve as a recruitment tool. Cardio-pulmonary resuscitation (CPR) training sessions should be scheduled and hosted regularly for the public, first responders, and other municipal and county personnel across all levels.

To strengthen the emergency medical services workforce in the north central region of Pennsylvania, and provide a unified strategy, agencies should coordinate and collaborate with existing training programs and educational facilities. This would help ensure that state-certified



emergency medical technician (EMT) and paramedic courses, ongoing education, and skill development are available for both staff and volunteers. Strategies include:

- Expanding access to certification programs
- Standardizing training quality
- Improving educational outcomes
- Supporting both volunteer and career pathways
- Leveraging workforce development programs and work-based learning, Registered Apprenticeship, incumbent worker training, and other strategies that support recruitment, skill development, retention, and career advancement.

Workforce Solutions for North Central PA can serve as a workforce development partner in these efforts by connecting eligible EMS employers with programs and resources that support workforce recruitment, training, retention, and advancement. Incumbent Worker Training (IWT) may assist eligible employers with the cost of training existing employees to develop new skills, advance within the organization, and strengthen workforce retention. Registered Apprenticeship capacity develops. EMS occupations such as Emergency Medical Technician and Paramedic could be evaluated for apprenticeship development based on employer interest, workforce demand, training requirements, and program feasibility.

Accessibility, Affordability, and Availability

Accessibility

Accessibility of training programs within and near the region studied should be coordinated among the different regional EMS councils in Pennsylvania. The councils should coordinate and provide information about training programs and continuing education classes that are offered in neighboring council areas as information bulletins that can be shared not only on each council's website, but across a shared, commonwealth-wide platform available to both responders and the general public. For emergency responders there currently is PA Train that addresses training opportunities on both in-person and virtual learning levels.

Affordability

Training costs are seen as potential barriers for many prospective EMS providers. Regional EMS councils and EMS services should consider scholarships, tuition assistance, and grants for potential EMT, AEMT, and paramedic candidates to attend these necessary programs. The intended awardees could be bound by agreements to remain within a specific service area or within the regional council area for a period of time in return for their awarded training cost relief or forgiveness.



Grant opportunities for certifications could be considered to help responders with their initial training or to further their EMS careers. Municipalities and counties could assist EMS agencies with grant funding research and application. The Federal Emergency Management Agency (FEMA), in FY2025 released a notice of funding opportunity related to the Assistance to Firefighters Grant (AFG) in which training is listed as a high priority among the categories for potential awards.

EmergyCare, as a provider developed a successful model for the recruitment, education, and employment of EMS providers within their coverage area. Individuals hired are enrolled within their in-house training program, compensated during the training, and remain as a provider for the organization.

Workforce development funding should also be considered as part of the region's strategy for reducing training-related financial barriers. Depending on employer and participant eligibility, workforce programs may help support training for new and existing EMS personnel. Incumbent Worker Training may assist eligible employers with the cost of training and work-based learning for individuals entering the EMS workforce.

Availability

By providing monthly continuing education (con-ed) on virtual platforms across multiple municipalities and counties, training programs could be made readily available to a large geographic area of responders, thereby alleviating the need for travel too far outside of the providers' response area. Instruction could be provided by different training providers as this would present different viewpoints, best practices, and lessons learned.

Partnerships with local schools, post-secondary, and institutions to provide initial certification training and regular con-ed offerings could ensure the availability of training to more than one EMS agency, paid or volunteer, quick response service (QRS), basic life support (BLS), and advanced life support (ALS), providers within a community.

Identify opportunities for partnerships with schools, post-secondary institutions, and Workforce Solutions

EMS agencies should be encouraged to form partnerships with Workforce Solutions, Northern Pennsylvania Regional College, Butler County Community College, Pennsylvania College of Technology, Clarion County Career Center, and other technical schools across the region to train providers. The partnerships across a wide region could develop a sustainable EMS workforce. Partnerships would foster ride-along instruction and learning opportunities, and possible placement partnerships or other career pathways after successful program completion.



Expanding the availability of training programs in rural Pennsylvania is critical. Agreements with agencies who have training facilities incorporated within their services could be negotiated with to provide training partnerships with other EMS providers. These agreements could engage more students per class and provide greater lessons learned across the region.

Counties, municipalities, and/or agencies could maintain these partnerships by incentivizing the organizations through direct and indirect funding.

Recommend mentorships, apprenticeships, or accelerated pathways for training

To address workforce readiness gaps, EMS agencies should implement apprenticeship models, encouraging local, experienced providers (EMT/paramedics) to provide mentorship within their communities. Regional EMS councils could also promote EMS agencies (paid/volunteer) to appoint an internal training team, thereby becoming mentors for new providers. Incentives could be considered for EMS providers who mentor new employees/volunteers to further their careers. Potentially, career development pathways for experienced providers could be established to develop an ongoing pipeline of instructors with significant experience. EMT development through paramedic, and eventually EMS instructor provides future candidates with an instructor pool from which to develop their skills and knowledge. These incentives could include a spotlight on the regional EMS council's website or some type of stipend.

Through EMS providers and educational facilities, apprenticeships could be developed with high schools and post-secondary institutions. Apprenticeships, similar to typical trades where knowledge and experience are gained through an apprentice, journeyman, and eventually master, offer real-world experience, improved clinical confidence, and bridge the gap between classroom learning and on-the-street performance.

Examine state vs. national certification requirements and their workforce implications.

Currently, Pennsylvania relies on the National Registry certification pathway for the certification of all EMS providers.

Training programs may not spend enough time on the national registry emergency medical technician (NREMT) requirements for students to be prepared for the certification testing. This issue may require the EMS student to take the examination numerous times. This re-testing is often dependent upon the student's ability to afford the additional test fees. Repeated attempt failures can discourage potential candidates from completing the program. Addressing these issues requires enhanced alignment between training programs and certification expectation.



Northern Pennsylvania Regional College (NPRC), operates as a rural-focused EMS training provider, delivers flexible, competency-based EMS education primarily through blended learning models. Programs emphasize accessibility for rural students across a ten-county region, strong completion and certification outcomes (90% National Registry pass rate for EMTs in recent years), and proactive student support. The organization is expanding their training offerings while maintaining high flexibility for volunteers and career entrants.

Key strengths include geographic reach, low attrition, and willingness to accommodate students. Challenges faced through delivery of training and certification center on mindset factors, and generational resistance to modern formats.

Students within NPRC primarily range from 18-30 years old, with a smaller cohort of older adults (including near or post-retirement). The majority come from volunteer fire/EMS departments, particularly from counties with larger population centers. Career changers and new entrants are both represented. Dual enrollment with high schools (currently grant-funded and free) provides an early pipeline into EMS careers or related degrees.

Targeted Student Support (TSS) counselors guide participants throughout the program. An entrance exam identifies potential barriers early, such as academic readiness (National Registry is written at ~9th grade level), technology access (loaner computers available), or need for accommodations. This proactive intervention has correlated with improved pass rates.

Ensuring high quality instruction depends upon well-trained instructors, sound educational programs, and supportive pathways to success.

Maintaining Instructor Compliance

Instruction should meet or exceed the National Registry standards, provide frameworks to improve provider portability and career advancement, enhance consistency in clinical knowledge and assessment methods, and strengthen preparedness for interstate or mutual-aid considerations.

Recommend approaches for regional consistency in protocol updates, instructor training, and education delivery

Protocol Updates

The regional EMS councils should assist with protocol updates by initially providing focused training for the regional EMS instructors, followed by providing training sessions on the new protocols to the providers.

Instructor training



Training for instructors should be uniform across the Commonwealth. Within the regional EMS council, instructors should be monitored to ensure they are following the established standards, teaching the curriculum, and encouraging successful completion of the program.

Education delivery

Feedback from interviews and survey respondents suggest there are several gaps in current training practices:

- Limited hands-on training experience
- Insufficient patient assessment practice
- Lack of advanced skills training

While the responses identified exist within the realities of certain responders, the actual nature of course instruction identified by an existing educational institution suggests multiple pathways to success. Through blended learning models, student date and location scheduled labs, training student support, and pre-testing to determine additional student support needs, opportunities to succeed abound. Standardization across the commonwealth of these successors should be the goal to continued certification.

The EMS workforce shortage in Pennsylvania is a complex challenge that requires coordinated and multi-sectored solutions. Training and certification systems play a critical role. Addressing barriers related to accessibility, affordability, and standard quality instruction are essential to sustaining a capable and resilient EMS workforce.

EMS services, local municipalities, county government, state government, education, and Workforce Solutions can collaborate to develop a comprehensive plan by following the suggested actions to alleviate these issues surrounding certification and training.

The identified shortage of EMS personnel and readily available training is a common issue that will not be resolved without change. To enhance the EMS system in the region studied, the following should be carefully reviewed and considered, and implemented to improve EMS recruitment and retention, and training and certification availability:

1. Certification & Continuing Education – Coordinate EMT, AEMT and paramedic certification through collaborative efforts with existing educational training facilities to enhance provider competency and retention.
2. Continuing Education Notices and Availability – Maintain and share available continuing education classes throughout the region on a mutual platform shared by all.



3. Expand hands on training – Develop and implement annual regional training opportunities as conducted in previous years to enhance skills and coordination efforts.
4. Teach to the National Registry Standard – Encourage all staff to be trained to this standard.
5. Public CPR/AED & Awareness Programs – Conduct CPR/AED training for first responders and community members, increasing emergency preparedness and recruitment opportunities.
6. Community Engagement – Continue the existing county-wide public education initiatives to improve awareness of EMS functions and when to call 911, ensuring appropriate utilization of emergency services.

The above items will guide the region studied and Workforce Solutions to the next phase of the project: standardization or training and certification of EMS providers within the region.

Hospital Interface

Emergency medical services (EMS) are part of the overall healthcare system, and routinely interface with multiple receiving facilities throughout the region studied. EMS resource availability is limited and must be available to their primary and secondary response areas as much as possible. As such, their interface with receiving hospital facilities is a critical element to assisting them in returning to service quickly. Typical interaction between the EMS crews and hospital staff occurs prior to arrival through a radio report including BLS report, nurse report, or obtaining medical command, informing the emergency room staff of the incoming patient and ability to prepare either a trauma bay, medical bay, specialty care services or other areas within the emergency room where the patient will be located. Emergency room staff taking the reports or providing medical command will typically provide an update to their team and/or prepare for the patient's arrival, possibly including the notification of additional staff who are not necessarily assigned to the emergency room: stroke patients, trauma patients, etc.

In most cases, the interface between EMS and hospital staff is routine and adequate where the staff are immediately available to meet the EMS crew and take report from the EMT or paramedic. However, through the survey and interviews, while mostly positive, several respondents identified difficult interaction with receiving facility staff including delays, staff unfamiliar with the pending arrival of a patient, all of which introduce delays for the EMS crews and lengthen their time returning to an available status. Hospital liaisons assigned to EMS crews may or may not be aware of all the lengthy interactions or incidents that introduce delays in locating a bay or bed availability. Through the liaison, EMS crew concerns should be identified



and relayed immediately whereby the facility liaison and staff may work to identify potential corrective measures allowing for more expeditious patient handoff to the receiving facility staff.

EMS Interface with Receiving Facilities: Challenges, Delays, and Opportunities for Improvement

Emergency Medical Services (EMS) function as a critical entry point into the healthcare system, providing rapid assessment, stabilization, and transport of patients to appropriate receiving facilities. The interface between EMS crews and hospital emergency department (ED) staff represents one of the most important transitions in patient care. This interface directly impacts not only patient outcomes but also EMS system efficiency, response coverage, and overall system sustainability.

Under typical operating conditions, EMS crews establish early communication with receiving facilities via radio or other communication platforms. This interaction may include a basic life support (BLS) report, an advanced life support (ALS) nurse or physician-level report, or direct medical command consultation. The purpose of this communication is to provide critical patient information, including chief complaint, vital signs, mechanism of injury, estimated time of arrival (ETA), and any interventions already performed. This allows the receiving facility to prepare appropriate resources, such as allocating a trauma bay, stroke team activation, or specialty care resources.

In most cases, this interface functions as intended, with hospital staff prepared to receive patients upon arrival and EMS crews able to transfer patient care efficiently. However, survey responses and stakeholder interviews reveal that while the system is generally effective, there are recurring and often systemic delays that impact EMS turnaround times and operational readiness. These delays, though sometimes perceived as isolated incidents, collectively contribute to increased out-of-service times, reduced EMS unit availability, and increased stress on the system.

Delays in Patient Handoff upon Arrival

One of the most frequently cited issues is the delay in transferring patient care from EMS to hospital staff. Upon arrival, EMS crews may experience difficulty locating available staff to receive the patient or may encounter situations where the ED is overcrowded and lacks available treatment space.

These delays may include:

- Waiting for an available bed or treatment bay, which at times can be upwards of 30 minutes.



- Holding patients in hallways or triage areas
- Prolonged wait times before a nurse or physician is available to receive report

Such delays extend the time EMS crews remain with the patient, reducing their ability to respond to additional calls.

Inconsistent Awareness of Incoming Patients

Despite pre-arrival radio reports, some respondents identified situations where ED staff appeared unaware of incoming patients. This may occur due to:

- Breakdown in internal communication within the hospital
- Failure to relay EMS radio reports to appropriate personnel
- Competing priorities within the emergency department

This gap results in EMS crews arriving at a facility that is not prepared, thereby increasing handoff time and creating inefficiencies. The lack of communication and sharing critical incoming patient data can have severe impacts to patient care once the patient arrives at the hospital campus. EMS leadership should convene meetings with emergency department leaders to discuss this weak link in the chain of patient care.

Emergency Department Overcrowding and Throughput Issues

Hospital overcrowding and ED boarding (patients remaining in the ED awaiting inpatient beds) significantly affect EMS operations. When ED capacity is exceeded:

- Ambulances may be required to “wall hold” with patients
- EMS crews may remain responsible for patient monitoring longer than intended
- Hospitals may temporarily divert or limit patient intake
- Hospitals may transfer patients from their facility to another facility which requires additional EMS resources

At times, EMS crews have been met by a triage nurse and then advised placing the patient in a waiting room chair. These conditions are often outside EMS control but have a direct and substantial impact on EMS availability. EMS should have a goal from arrival at the ED to available and returning to station of fifteen minutes or less. Additional meeting with ED managers would assist with the identification and mitigation of this issue.



Delays in Medical Command and Pre-Arrival Communication

Obtaining medical command or providing a radio report can occasionally be delayed due to:

- Busy communication channels
- Delayed physician or nurse response
- Variability in communication protocols across facilities

The delay of medic command services can have a drastic impact on the EMS care plan in place at the time of request for command. An EMS provider calls medic command for rapid assistance with directions and orders for further patient care to enhance the patient's survival and outcome. Inconsistent communication processes can increase uncertainty and reduce the effectiveness of pre-arrival preparation which ultimately impacts patient care.

Documentation and Administrative Delays

EMS crews are required to complete patient care reports (PCRs) and, in many cases, obtain signatures from receiving staff. EMS crews also need to acquire patient demographics from the registration process. Insurance information, address, and other information is critical for the PCR and for future billing for service. Delays may occur when:

- Staff are unavailable to sign documentation
- Electronic systems are incompatible or inefficient
- Documentation requirements are time-consuming
- Registration of the patient takes extended periods of time to complete

These administrative processes, while necessary, can prolong EMS turnaround times if not streamlined.

Variability in Hospital Processes and Procedures

Each receiving facility may have its own policies regarding patient intake, triage, and EMS handoff. This lack of standardization can create confusion and inefficiency, particularly for EMS crews operating across multiple facilities.

Examples include:

- Different expectations for report format
- Variations in triage processes
- Inconsistent use of EMS liaison roles

Limited Visibility of Operational Delays by Hospital Leadership



Hospital EMS liaisons are often tasked with maintaining relationships between EMS agencies and the ED. However, these individuals may not be fully aware of all delays or operational challenges experienced by EMS crews.

This lack of visibility can result in:

- Underreporting of systemic issues
- Missed opportunities for process improvement
- Persistent operational inefficiencies

System-Level Impacts of Delays

The cumulative effect of these delays extends beyond individual incidents and has broader system implications:

- **Reduced EMS Unit Availability:** Units remain out of service longer, increasing response times in the community.
- **Increased Mutual Aid Dependence:** Neighboring agencies are required to cover gaps, compounding system stress.
- **Provider Fatigue and Burnout:** Extended wait times contribute to frustration and reduced morale among EMS personnel.
- **Public Safety Risk:** Delayed EMS availability may impact response times for critical incidents.

The interface between EMS and hospital emergency departments is a critical component of the healthcare delivery system, directly influencing both patient outcomes and EMS operational effectiveness. While the current system generally functions adequately, the identified delays, ranging from communication gaps to overcrowding and administrative inefficiencies, represent significant opportunities for improvement.

Addressing these challenges will require a coordinated, system-wide approach involving EMS agencies, hospital leadership, and regional stakeholders. By implementing standardized processes, enhancing communication, leveraging technology, and fostering collaboration, the system can reduce delays, improve patient care transitions, and ensure EMS resources remain available to serve the community effectively.

Ultimately, improving the EMS-to-hospital interface is not solely an operational necessity but a strategic priority that supports the sustainability and resilience of the entire emergency care system.



Resource Allocation

EMS unit availability, upon clearing from a hospital, must be shared with the 9-1-1 dispatch center responsible for notifying EMS agencies of new calls for service. Often, EMS units may not provide an “available” status change or notify the Public Safety Answering Point (PSAP) that they have cleared from a hospital and may be available to handle another call for service.

Alternatively, an EMS unit may consider themselves too far away from their area of coverage to be “available,” although if another call for service is dispatched, the EMS unit could begin to head toward the address for service, especially in the event that another EMS unit or mutual aid EMS agency has a difficult time establishing a crew to handle the call. Coordination through the PSAP of all EMS units is imperative to allow the closest, most appropriate EMS unit to handle the call for service.

As a recommendation, and in concert with the PSAPs, EMS agencies should equip all emergency medical services vehicles with mobile data terminals for tracking other EMS units, enhanced communications, and completion of patient care records in transit.

Completion of patient care records in transit reduces the necessity for crews to complete documentation on return to station and potentially eliminates the need for staff to remain on duty beyond their scheduled shifts. Realized benefits include reduced overtime potential and crew burn out.



Recommendations

Enhanced Financial Stability through Business Management

EMS, whether volunteer, or non-profit, is a business. The primary functions of a business include management, finance, operations, human resources, and customer service. Each of these functions is as crucial in EMS as it is in any business. Administrators in EMS are often the most senior paramedic or EMT, or the one willing to take on the administrative tasks. Business management training, mentorship, and/or experience can greatly enhance the operations of an EMS agency, thereby enhancing customer service, which in this respect is patient treatment.

Management is the process of planning, organizing, leading, and controlling an organization's resources and activities to achieve its goals efficiently and effectively. This includes scheduling resources to achieve goals in the most efficient manner. In EMS this includes reaching and treating the patient quickly, transporting, if required, to the most appropriate facility, returning to service, billing, and receiving revenue. Effective management includes consistent pre-and-post incident planning and tasks.

Finance includes the management of a company's monetary resources to support operations, growth, and strategic decision making. Financial management of EMS is one of the most challenging aspects. Administrators are being asked to do great things with small resources, and balance a system where expense often exceeds revenue, and often due to circumstances outside the control of the agency, including reimbursement limits, cost of third-party invoicing, and insurance being paid to the insured instead of the service. Funding shortages in EMS do not necessarily point to poor management, but there is potential to improve individually and collaboratively. In-house billing, municipal/county support for billing, or shared/collaborative billing could reduce or eliminate vendor costs. Collaborative purchasing may reduce per piece and shipping costs for some equipment and supplies. Additionally, training in budgeting, forecasting, depreciation, and capital purchasing could aid in better long-term financial stability.

Business operations are the day-to-day activities, processes and systems that are used to produce goods or deliver services that generate revenue. This is the primary function of EMS. Help the patient. That is your service. Staff are scheduled, they ensure that the equipment is ready, they have been trained to respond, they aid the person in need, get them to the next level of care, return, and reset. While this is the revenue generator, it rarely generates enough revenue due to the constraints discussed previously. Municipal or county support for billing or in-house billing could help to improve revenue. Continued lobbying for improved reimbursement rates and methods of reimbursement are also important to the generation of revenue.



“Great EMS services are managed by leadership with a high level of tenure and someone with business acumen.”

Human Resources is the function that manages human capital, the paramedics, EMTs, and other employees. In the six-county study region both volunteer and paid services prioritize their personnel. Pay and benefit programs are similar in the region and comparable to the state. Volunteer agencies support their staff with training assistance, and gear. All agencies prioritize morale with holiday gifts and celebrations, group appreciation activities, and support. County-wide or regional appreciation events sponsored by companies, municipalities, or counties could help agencies prioritize personnel and limit cost to the agencies.

Customer service is the primary place where EMS lives. Responding to the calls, patient care, improving and saving lives. This is the goal and objective, and success of EMS. Overall, the study region reported high “customer satisfaction” rates with residents believing that EMS providing them with the best service that they are able. Other sections of this report will touch on ways that EMS can improve customer service, which will also aid in enhancing human resources.

Workforce Solutions for North Central Pennsylvania could play a role in the enhancement of financial stability through business management by acting as a regional resource for training, collaboration, and resource identification. Financial stability can also be paired with MIH-CP as it creates a larger business model which will require astute management.

Staffing, Coverage, and Deployment

Emergency Medical Services staffing, coverage, and deployment models form the foundation of prehospital care delivery systems. These components directly influence how quickly ambulances reach patients, how consistently service is maintained, and how efficiently agencies use their personnel and financial resources. Although EMS systems vary widely depending on geography, call volume, and funding, agencies must deliver timely care while managing limited staff, managing budgeted personnel costs, and avoiding excessive workload on crews.

Staffing models define how personnel are hired, scheduled, and assigned to units. In career systems, full-time employees may work structured shifts such as 24-hour tours or 12-hour rotations, which provide reliable and predictable coverage but come with higher costs related to salaries, benefits, and overtime. Volunteer systems, which are more common in rural areas, depend on individuals responding from home or work. While this approach reduces costs, it can



create gaps in coverage and slower response times, particularly during the day. And, as discussed in this report, there is a significant declination of available resources when it comes to the availability and quantity of individuals in the pipeline who contribute to the makeup of volunteers. Combination systems blend these two approaches by using paid staff to ensure minimum coverage and supplementing them with available volunteers during busy periods or large incidents, offering a balance between cost control and reliability.

Scheduling plays an important role in how well staffing aligns with call demand. Fixed schedules, including common formats like 24-on/48-off, provide consistency and are easier to manage, but they do not always match when calls are most frequent. To address this, many agencies add flexible staffing such as peak-load units or part-time shifts during high-demand times like evenings or weekends. This allows agencies to improve response times without significantly increasing full-time staffing, though it can make scheduling more complex and increase reliance on overtime or part-time personnel. Several successful EMS agencies within the studied region deploy scheduling initially defined as family-first scheduling that incorporates volunteers and employees who sign-up to work shifts that provide them maximum flexibility.

Coverage models determine where ambulances are positioned within a service area. Traditional station-based coverage assigns units to fixed locations, which works well in areas with lower call volume and supports crew rest and familiarity with their response area. However, in busier systems, this approach can lead to inefficiencies if units are located far from where the next call occurs. To improve performance, many agencies use dynamic deployment, where units are moved throughout the day based on predicted demand. This can reduce response times but requires crews to stay mobile and can contribute to fatigue. As a result, many systems use a hybrid approach, maintaining some station-based coverage while allowing limited repositioning when needed.

Deployment strategies define how resources are sent to calls. Most systems use closest-unit response, sending the nearest available ambulance regardless of jurisdiction, which improves response times but requires coordination between agencies. Many also use tiered response models, sending different levels of care depending on the severity of the call, for example, Basic Life Support units for low-priority incidents and Advanced Life Support units for critical emergencies. Some systems also deploy non-transport units, such as paramedic fly cars or quick response vehicles, which can provide advanced care quickly without transporting patients, helping maintain coverage when ambulances are tied up.

Performance is often measured using metrics like unit-hour utilization and response time reliability. Utilization reflects how much time crews spend on calls versus being available. While



higher utilization can indicate efficiency, excessively high levels can lead to fatigue and burnout. Response time reliability, often measured using benchmarks like the 90th percentile, gives a clearer picture of how consistently the system meets response time goals compared to simple averages.

Rural EMS systems face additional challenges, including long travel distances, limited personnel, and lower call volumes. In these areas, maintaining basic coverage is often more important than optimizing response times for every call. Agencies may rely on volunteers, cross-trained personnel, mutual aid agreements, or regional partnerships to ensure service availability. Alternative approaches such as community paramedicine or scheduled standby coverage can help address gaps in service.

Ultimately, effective EMS system design requires ongoing evaluation and adjustment. Agencies use tools such as GIS mapping, dispatch data, and historical call patterns to determine where resources are needed and how staffing should be structured. Regular review of system performance allows agencies to adapt to changing demand and improve efficiency. Because no single model works for every environment, successful systems are those that remain flexible, data-driven, and focused on both operational performance and workforce sustainability.

EMS agencies should strengthen staffing models by moving toward a balanced combination approach that ensures consistent baseline coverage while maintaining flexibility to handle demand fluctuations. This includes maintaining a core group of full-time personnel to guarantee minimum staffing levels, while supplementing with part-time staff and volunteers where available. Given the ongoing decline in volunteer participation, agencies should prioritize recruitment and retention strategies, including incentives, training pipelines, and flexible participation options. Expanding “family-first” or self-scheduling models can improve workforce satisfaction and availability by allowing personnel to select shifts that align with their personal schedules, ultimately supporting long-term sustainability and reducing burnout.

While fixed schedules provide stability, they should be supplemented with peak-load or flex units that are deployed during historically busy periods such as evenings, weekends, and seasonal spikes. This approach allows agencies to improve response times without significantly increasing full-time staffing costs. However, to make this effective, agencies must invest in workforce planning tools and ensure adequate availability of part-time or per diem personnel to fill these targeted shifts.

Coverage can be improved by transitioning from purely station-based models to hybrid systems that combine fixed deployment with selective dynamic positioning. Maintaining station-based units is still important, but agencies in higher-demand areas should incorporate controlled system



status management practices to reposition units based on real-time or predicted demand. These adjustments should be used strategically to fill coverage gaps and reduce response times, while avoiding excessive movement.

Deployment practices should prioritize efficiency and appropriate resource utilization by expanding the use of closest-unit response and tiered dispatching. Agencies should work to strengthen mutual aid agreements and interoperability with neighboring jurisdictions to ensure the closest appropriate unit is dispatched regardless of boundaries. At the same time, tiered response systems should be refined so that higher-level ALS resources are reserved for critical calls, while BLS units handle lower-acuity incidents. This improves system efficiency and ensures that advanced resources remain available when truly needed.

Agencies should also consider increasing the use of non-transport resources, such as quick response vehicles or paramedic intercept units, especially in rural or geographically large service areas. These units can provide rapid advanced care without removing transport ambulances from service for extended periods. Proper coordination between transport and non-transport resources is essential to ensure timely patient movement when needed.

Performance monitoring should be strengthened by concentrating on metrics such as unit-hour utilization and response time reliability.

UHU, or unit hour utilization, itself is fairly straightforward. Unit Hour Utilization (UHU) is calculated by dividing the number of EMS transports by the number of “unit hours,” with one unit hour defined as a fully equipped and staffed vehicle in your EMS system. If your system has 10 ambulances around the clock, there are 240 unit hours in a 24-hour period. If those 10 ambulances do 120 transports in 24 hours, you would calculate your system’s UHU as follows:

$$120 \text{ transports} / 240 \text{ unit hours} = .5 \text{ UHU}$$

The higher the ratio, the more productive the system, in the sense that you’re getting more transports out of fewer ambulances.

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Agencies should aim to keep utilization at a level that balances efficiency with crew availability, avoiding excessive workloads that lead to fatigue and burnout. Response performance should be evaluated using reliability measures to better understand consistency rather than relying solely on

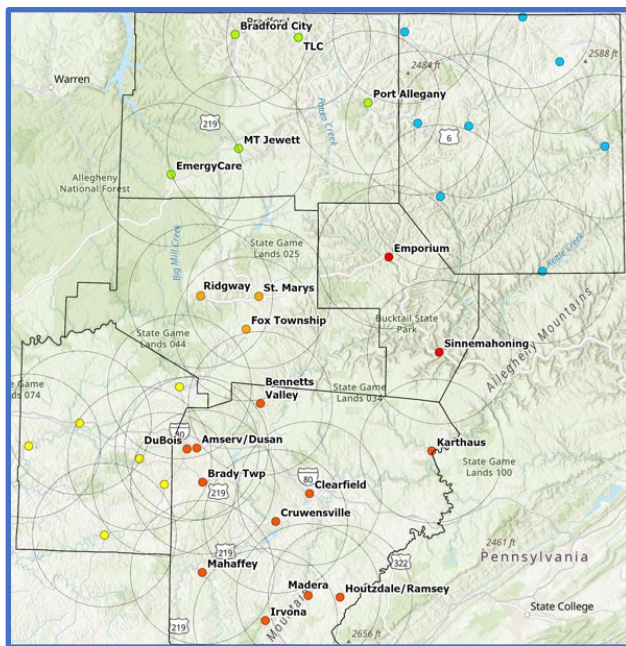


averages. Regular review of these metrics should guide adjustments to staffing levels, unit placement, and deployment strategies.

Finally, EMS systems, particularly in rural areas, should prioritize maintaining consistent minimum coverage while exploring regional and collaborative solutions. This may include shared services, cross-trained personnel, and expanded mutual aid agreements. Across all system types, ongoing use of data analysis tools such as GIS mapping and CAD data is essential to continuously refine staffing, coverage, and deployment decisions.

Station Placement, Staffing and Deployment

A review of EMS station locations across Cameron, Clearfield, Elk, Jefferson, McKean, and Potter Counties shows that, at a high level, the region maintains generally strong geographic coverage. Stations are distributed in a way that places EMS resources within reasonable proximity of most population centers. However, it is important to understand that station placement in this region cannot be evaluated based on location alone. Instead, it must be viewed holistically by considering three key factors together: where people live, how far apart stations are, and how long it actually takes to travel between them given the rural terrain and roadway limitations.





Although the maps show stations positioned within varying distances, this distance does not directly translate into quick response times. In a rural and mountainous environment such as this, that distance often results in twenty-to-thirty-five-minute drive times under normal conditions, and potentially much longer when factoring in snow, ice, limited roadway connectivity, or responses into remote areas such as state game lands. This means that even though stations may appear reasonably spaced on a map, real-world response times can be significantly impacted by geography, making coverage more fragile than it initially appears.

The maps that include ten-mile service buffers help illustrate another important concept: coverage on paper does not always equal reliable service. While many communities fall within these buffer zones, the actual ability to respond quickly depends on the road network, elevation changes, and travel routes, not straight-line distance. This is especially evident in the northern counties where stations are fewer and spread farther apart. In these areas, it is realistic to expect response or support times between stations to extend beyond thirty to forty-five minutes, particularly for remote locations. By contrast, the southern portion of the region, primarily Clearfield and Jefferson Counties, has a much denser concentration of stations, resulting in overlapping buffers and shorter travel distances.

These differences are largely explained by population distribution. Clearfield, Elk, and Jefferson Counties contain larger population centers, higher call volumes, and more developed transportation corridors. Potter, Cameron, and parts of McKean County are among the most rural and sparsely populated areas. In these locations, EMS stations must cover much larger geographic areas with significantly fewer calls, which creates operational challenges in maintaining both efficiency and service availability.

Given this uneven distribution, there are targeted opportunities for system optimization, particularly in the southern counties. In areas like Clearfield and Jefferson, the close proximity of stations, often within the lower end of the 15-mile spacing and with overlapping buffers suggests that there may be redundancy in infrastructure and resources. In these locations, it may be reasonable to explore:

- Consolidating certain stations where call volume or staffing levels do not justify separate operations
- Creating regional or shared staffing models across municipalities
- Developing centralized “hub” stations that support surrounding areas rather than maintaining multiple minimally staffed locations



Similarly, there are opportunities to improve efficiency through shared use of vehicles and equipment. For example, rather than fully equipping every station, agencies could adopt models such as:

- Dynamic deployment (System Status Management), where units are positioned based on demand rather than fixed locations
- Shared backup or reserve ambulances across agencies
- Regional ALS intercept units, reducing duplication of advanced life support capabilities

However, it is critical to balance these opportunities with the risks involved. What may appear to be redundant coverage on a map may actually be necessary system resiliency, particularly in a region where transport times to hospitals are long and units are frequently unavailable for extended periods. Reducing stations or combining resources without careful analysis could lead to:

- Increased response times during simultaneous calls
- Reduced system reliability when units are already committed
- Coverage gaps in outlying or hard-to-reach areas

Importantly, this report highlights that workforce availability is one of the most significant constraints on the system, and this factor must be considered alongside any discussion about station consolidation. The available EMS workforce pool in the region is limited, with many agencies experiencing staff shortages, reliance on part-time personnel, and challenges maintaining consistent 24/7 coverage. Resources are spread thin across too many locations, leading to underutilized stations that cannot be reliably staffed. Consolidation, when done carefully, can actually strengthen staffing models by concentrating limited personnel into fewer, better-supported locations, improving overall unit availability and service reliability.

In the northern counties, however, the situation is fundamentally different. The current station distribution reflects minimal coverage serving large, rural areas, and there are very few opportunities to eliminate or combine stations without creating unacceptable service gaps. Instead, these counties would benefit more from enhanced coordination and regional collaboration, such as:

- Improved mutual aid agreements across county lines
- Efficient dispatch and resource allocation practices
- Strategic relocation (rather than elimination) of stations to better align with population centers



- Use of alternative response models, including community paramedicine or tiered response systems

Another key observation is the critical importance of certain isolated stations, particularly in areas like Emporium, Sinnemahoning, Karthaus, and eastern Potter County. These locations serve as essential access points to otherwise hard-to-reach communities. Even if call volumes are low, these stations play a vital role in maintaining baseline emergency access, and their removal would likely result in significant delays that exceed acceptable response standards. There are, however, opportunities to combine staffing and share resources across the area through carefully coordinated efforts. In specific areas, high did not crew rates, where EMS agencies are unable to provide a crew for a call, provide an opportunity for agencies to transition into the role as a quick response service to begin patient care while awaiting the arrival of a transport capable ambulance. In these areas, significant costs are expended within services unable to provide consistent coverage, yet without their minimally available crews, patients wait considerable times for help.

Ultimately, any effective path forward is not a broad reduction in stations, but rather a balanced, regional approach to system design. This could include:

- Carefully targeted consolidation in higher-density areas to improve efficiency and staffing
- Preservation and support of critical rural access points
- Increased regional governance or coordination to align resources across counties
- Standardization of operations, protocols, and deployment strategies

Finally, it is essential to recognize that station location alone does not determine system performance. The most important factor is unit availability, whether an ambulance and crew are actually ready to respond when needed. A well-placed station network will still fail if units are understaffed or frequently unavailable. For this reason, any decision regarding consolidation or restructuring must be supported by:

- Call volume and demand patterns
- Unit Hour Utilization (UHU)
- Time-on-task and hospital turnaround times
- Seasonal and weather-related impacts
- Workforce availability and staffing sustainability

In summary, the region studied demonstrates generally effective geographic coverage, but with clear differences between more densely populated southern counties and sparsely populated



northern areas. Opportunities exist to improve efficiency through consolidation and shared resources, particularly where stations are clustered and staffing is stretched. However, these decisions must be made carefully, with full consideration of response time impacts, rural access needs, and, most critically, the limitations of the available EMS workforce pool. A thoughtful, data-driven, and regionally coordinated approach will be necessary to strengthen the system without compromising service delivery.

Regional Coordination

Regional coordination improves EMS service by shifting the system from a collection of independent, locally operated agencies into a connected network of shared resources, which is especially important in rural areas like the counties shown in your maps. In practical terms, it allows agencies to work together as a single system rather than as isolated providers, improving both efficiency and reliability.

Regional coordination improves resource availability and reliability of response. In a fragmented system, each locality relies primarily on its own units, which can quickly become unavailable due to long transport times or staffing shortages. Through coordination, such as automatic aid agreements and shared dispatch protocols, the closest available unit can be sent to a call regardless of jurisdiction. This is particularly important in the northern counties (Potter, Cameron, McKean), where station spacing is wide and individual agencies may only have one unit available at a time. Regional coordination effectively expands the functional coverage area of each unit, reducing the likelihood that a community is left without immediate response when its local ambulance is committed.

Coordination helps address the most critical challenges identified in the report: limited workforce availability. The available EMS workforce pool in this region is constrained, with many agencies struggling to staff units consistently. When agencies operate independently, limited personnel are spread thin across multiple stations, sometimes resulting in partially staffed or unreliable coverage. Regional approaches, such as shared staffing models, cross-credentialing personnel, or pooled coverage schedules, allow agencies to concentrate staff where they are most needed, improving unit availability without requiring additional personnel. In this way, regional coordination serves as a force multiplier for a limited workforce, enhancing service without increasing staffing levels.

Regional coordination supports more efficient deployment of resources. Instead of keeping ambulances fixed at individual stations, coordinated systems can implement strategies like dynamic deployment or system status management, positioning units based on real-time demand patterns. This is particularly effective in the southern counties (Clearfield and Jefferson), where



there is higher call volume and overlapping station coverage. Coordinated deployment can reduce unnecessary duplication of coverage while still maintaining response performance, ultimately improving both efficiency and cost-effectiveness.

Coordination enables shared capital resources and cost savings. Agencies can reduce redundancy by sharing:

- Reserve or backup ambulances
- Specialized equipment (e.g., ALS gear, bariatric units)
- Maintenance facilities
- Administrative and billing functions

Rather than each agency independently maintaining full infrastructure, a regional model allows for economies of scale, which is especially valuable in areas where funding and staffing are already constrained.

Regional coordination strengthens clinical and operational consistency. By aligning protocols, training standards, and quality assurance processes, agencies across the region can provide a more uniform level of care, regardless of where a patient is located. This is particularly beneficial when units cross jurisdictional lines for mutual aid, ensuring that care practices are consistent and predictable. It also supports better data sharing and system-wide performance improvement.

Coordination enhances resiliency during peak demand and large-scale incidents. In rural systems where individual agencies have limited surge capacity, regional coordination allows for rapid mobilization of additional resources across county lines. This is critical during:

- High call volume periods
- Severe weather events
- Major incidents or disasters

Without regional coordination, these events can quickly overwhelm isolated agencies.

At the same time, regional coordination does not necessarily mean eliminating stations or reducing local presence, especially in geographically isolated areas. Instead, it allows the system to better optimize existing assets, particularly by:

- Supporting rural stations with regional backup
- Reducing over-concentration in higher-density areas
- Allowing strategic consolidation without sacrificing coverage



In summary, regional coordination improves EMS service by making better use of limited resources, especially workforce, while improving reliability, efficiency, and response performance. In a region like the one analyzed, where geography is challenging and staffing is constrained, coordination is less about changing where stations are located and more about ensuring that available units and personnel are deployed effectively across the entire system.

Dispatch Integration

Throughout the region studied, respondents to the survey and subsequent interview discussions identified a lack of communication by agencies of their availability. Specifically, reporting when units or stations are out of service are not consistently reported, instead, only once an agency is dispatched to a call, then the dispatch center is apprised no unit is available for the call. This lack of communication builds inherent delays to responses and ultimately, patient care. Effective communication between EMS agencies and dispatch centers is critical to ensure that staffing plans translate into real-time operational readiness. Dispatch centers must have clear, up-to-date visibility of unit availability and scheduled resources throughout the day. This includes knowing which units are in service, when peak-load or flex units are scheduled to come online, and when units may be taken out of service due to staffing gaps, training, mechanical, or other issues. Defining and implementing standardized processes for reporting schedule changes, late staffing adjustments, and unexpected shortages allows dispatchers to make more informed decisions when assigning resources and managing system coverage.

In addition, strong coordination supports better situational awareness and more efficient resource utilization during periods of high demand. Regular communication protocols, such as shift/unit status updates, sharing crew schedules, and real-time system status monitoring help align field operations with dispatch decision-making. This level of coordination ensures that decisions are not made in isolation but are actively supporting deployment and coverage goals, ultimately improving response reliability while reducing unnecessary strain on personnel.

Public Education on Appropriate 911 Use and Alternative Healthcare Options

Effective public education regarding the appropriate use of 911 is essential to maintaining an efficient and responsive emergency medical services (EMS) system. County governments and public safety answering points (PSAPs), as well as other public safety agencies, have a shared responsibility to ensure residents understand when to call 911, what alternatives exist for non-emergency situations, and how to access the most appropriate resources. Many communities are experiencing a growing number of requests for service that do not require an ambulance response. Educating the public on proper healthcare navigation can help preserve emergency



resources for life-threatening situations, reduce healthcare costs, improve patient outcomes, and shorten ambulance response times for those experiencing true emergencies.

Public outreach efforts should clearly explain that 911 is intended for situations involving an immediate threat to life, health, safety, or property. Examples include symptoms of a heart attack, stroke, severe difficulty breathing, uncontrolled bleeding, serious trauma, suspected overdose, seizures, or any medical condition where a delay in care could result in significant harm or death. Educational messages should also emphasize that residents are not expected to diagnose emergencies themselves. If a person genuinely believes that an emergency may exist, calling 911 remains the appropriate course of action. Trained emergency medical dispatchers can assess the situation, provide instructions, and determine the appropriate response based on established protocols.

At the same time, governments could educate residents that not all medical concerns require an ambulance or an emergency department visit. Many individuals call 911 because they are uncertain where to turn for assistance, particularly after normal business hours. Public education campaigns should provide guidance on alternative healthcare resources that may be more appropriate for low-acuity or non-emergent medical issues. Primary care providers remain the preferred option for routine illnesses, medication questions, management of chronic medical conditions, and follow-up care. Urgent care centers can often address minor injuries, mild illnesses, sprains, strains, minor cuts, ear infections, and other conditions that require prompt attention but are not emergencies.

Counties should also promote the availability of nurse advice lines and telehealth services, many of which are offered through health insurance plans, hospital systems, and healthcare providers. These services can help residents determine the most appropriate level of care while reducing unnecessary ambulance requests and emergency department visits.

Behavioral health issues represent another important area of public education. Residents should be aware of local crisis intervention services, mobile crisis teams, and the National 988 Suicide & Crisis Lifeline for mental health concerns that do not involve an immediate threat to life or safety.

Another important component of public education involves informing residents about available transportation alternatives. In many cases, individuals seek ambulances primarily because they need transportation to a healthcare facility rather than emergency medical treatment. Educational materials should help residents understand that family members, friends, ride-share services, non-emergency medical transportation providers, senior transportation programs, and Medicaid-funded transportation services may be appropriate options when a person's condition is stable and does not require medical monitoring during transport. Educational campaigns must carefully



communicate that these alternatives are intended only for non-emergency situations and should never replace calling 911 when serious symptoms or life-threatening conditions are present.

To maximize effectiveness, governments and public safety agencies should coordinate to implement a structured, year-round public education program. Rather than relying on occasional outreach efforts, education should be delivered consistently through multiple channels and tailored to community needs. Quarterly public awareness campaigns can focus on topics such as recognizing stroke symptoms, understanding cardiac emergencies, appropriate ambulance utilization, fall prevention, mental health resources, and seasonal health concerns. Annual outreach events, including community fairs, senior expos, National Night Out activities, and healthcare fairs, provide opportunities for direct engagement with residents. School-based programs should also be incorporated to teach children how and when to call 911, helping establish appropriate emergency system utilization habits at an early age.

A successful educational strategy requires a comprehensive marketing and communications approach. Social media platforms offer an effective method for distributing short educational videos, infographics, and real-life examples demonstrating when residents should call 911 and when other care options may be more appropriate. Counties should maintain dedicated website resources that explain emergency versus non-emergency situations, provide frequently asked questions, and identify local healthcare and transportation resources. Email newsletters can reinforce these messages by reaching residents on a regular basis and highlighting seasonal healthcare topics.

Traditional communication methods remain equally important, particularly for aging populations and individuals who may have limited internet access and/or do not use social media platforms. Counties should partner with local television and radio stations to distribute public service announcements throughout the year. Printed brochures, posters, and educational handouts should be placed in libraries, schools, senior centers, physician offices, community centers, hospitals, and public health facilities. Additional exposure can be achieved through utility bill inserts, tax mailings, and county publications that direct residents to educational resources.

Partnerships with healthcare organizations and community stakeholders are critical to the success of these initiatives. Hospitals, health systems, primary care providers, federally qualified health centers, insurance companies, schools, faith-based organizations, senior living communities, and community service organizations can all help reinforce consistent messaging. By working collaboratively, these organizations can extend the reach of educational efforts and increase awareness among diverse populations throughout the county.

The effectiveness of a public education program should be evaluated regularly through measurable performance indicators. EMS agencies and PSAPs can assess changes in low-acuity ambulance utilization, monitor trends in emergency department use for non-emergent conditions,



evaluate public awareness through community surveys, and gather feedback from PSAP personnel regarding the appropriateness of incoming calls. Additional measures may include increased utilization of telehealth services, urgent care centers, non-emergency transportation programs, and other healthcare alternatives. By continuously evaluating outcomes and adapting educational strategies accordingly, counties can ensure that resources are being used effectively and that residents receive the right care at the right time.

A sustained, data-driven public education effort can significantly improve public understanding of emergency services and healthcare navigation. Through ongoing outreach, strategic partnerships, and consistent messaging, county governments and dispatch centers can help residents make informed decisions regarding emergency medical care. The result is a more efficient EMS system, improved patient access to appropriate healthcare services, reduced strain on emergency resources, and better overall outcomes for the communities they serve.

Reduce Hospital Turnaround Time

Reducing hospital turnaround time is one of the most effective ways to improve EMS system performance because it directly increases ambulance availability and reduces response delays. In the rural Pennsylvania EMS studied region, hospital time is driven less by EMS operations and more by emergency department (ED) throughput, but there are several strategies that EMS agencies and hospitals can implement collaboratively to improve efficiency.

The most impactful approach is establishing formal EMS–hospital offload expectations and agreements. Many high-performing systems set a target offload time of 20 minutes or less. This requires coordination with hospital leadership to define when a patient is considered transferred (for example, once care is verbally handed off to a nurse). Having clear expectations creates accountability and allows EMS services to track delays by facility. In Pennsylvania and nationally, agencies that routinely monitor and share hospital-specific turnaround data often see improved compliance simply because performance becomes transparent.

Another key strategy is the creation of EMS offload or triage areas within the hospital. These are designated spaces, often with chairs or monitored areas, where stable, low-acuity patients can be placed after a quick triage assessment rather than waiting for a bed. This model, sometimes called “vertical patient placement,” has been widely adopted in busy EDs and can significantly reduce ambulance wait times. Instead of crews holding the wall waiting for a room, they can transfer care quickly and return to service while the patient continues through the ED process.

Improving pre-arrival communication and hospital notification is also critical. When EMS provides early notification (including patient condition, acuity, and estimated time of arrival), hospitals can begin registration and triage planning before the ambulance arrives. Some



healthcare systems go further by integrating electronic patient care reports (ePCR) with hospital systems, allowing patient information to be transmitted in advance. This reduces delays associated with registration and intake and helps prioritize critical patients more efficiently.

A major operational improvement is streamlining the transfer-of-care process. Best practice is to allow for a rapid verbal handoff followed by delayed documentation, meaning the crew gives a concise report, transfers the patient to hospital staff, and completes charting after returning to service. Standardized handoff formats (such as IMIST-AMBO or SBAR) can make this process faster and more consistent while maintaining patient safety.

Another important strategy is using alternative destinations and non-transport options for appropriate patients. A significant portion of EMS calls, such as minor illness, behavioral health concerns, or repeat “frequent flyer” patients, do not require emergency department care. Programs such as treat-and-release protocols, referral to urgent care centers, or transport to behavioral health facilities can reduce ED crowding and, indirectly, ambulance wait times. Pennsylvania has increasingly supported these models through community paramedicine and expanded EMS protocols, and nationally they are considered a key component of modern EMS system design.

Addressing patient flow within the hospital is equally important. EMS agencies can partner with hospitals to identify bottlenecks such as delays in triage, lack of inpatient beds, or inefficient discharge processes. For example, hospitals that implement early discharge planning or improve inpatient bed turnover often see reduced ED congestion, which in turn reduces EMS offload delays. While EMS does not control these processes, collaborative performance improvement committees between EMS and hospitals can drive meaningful change.

From an EMS operations standpoint, agencies can also improve turnaround time through crew and process readiness. This includes ensuring that stretchers and equipment are quickly cleaned and reset, using standardized procedures for returning units to service, and minimizing downtime after patient transfer. While these steps may only save a few minutes per call, they add up significantly.

Technology can further enhance efficiency through real-time hospital status monitoring. Some systems use dashboards that show ED crowding levels or average offload times by hospital, allowing crews and dispatchers to make informed transport decisions when clinically appropriate. For example, diverting a stable patient to a less crowded facility may reduce turnaround time and keep more units available in the system.



Finally, data tracking and continuous quality improvement (CQI) are essential. Agencies should measure hospital time by unit, call type, and receiving facility, and regularly review this data with hospital partners. Tracking trends, such as peak delay times, high-delay facilities, or delays associated with certain patient types, allows for targeted interventions rather than broad, less effective solutions. Many systems also track 90th percentile times (not just averages) to better understand worst-case performance and system stress.

In summary, reducing hospital turnaround time requires a combination of EMS operational changes and strong collaboration with hospitals. The most effective solutions include setting clear offload expectations, creating dedicated EMS triage areas, improving pre-arrival communication, streamlining handoff processes, expanding alternative care pathways, and using data to drive continuous improvement. While no single solution eliminates delays, implementing several of these strategies together can significantly reduce time at the hospital, improve ambulance availability, and enhance overall EMS system performance.

Improve EMS–Hospital Interface Efficiency

Addressing these challenges requires a combination of operational, technological, and policy-level interventions.

Strengthen Pre-Arrival Communication Protocols

- Implement standardized radio report formats across all facilities
- Utilize digital pre-notification systems (e.g., electronic patient alerts)
- Require confirmation of receipt of EMS reports

These measures ensure that hospital staff are consistently aware of incoming patients and can prepare accordingly.

Establish Dedicated EMS Handoff Protocols

- Develop standardized handoff procedures with clear roles and responsibilities
- Utilize structured communication tools (e.g., SBAR: Situation, Background, Assessment, Recommendation)
- Implement “no delay” handoff policies where feasible

Standardization reduces variability and improves efficiency across facilities.

Designate EMS Liaison Roles with Enhanced Oversight

- Assign dedicated EMS liaisons within hospitals to monitor EMS interactions



- Conduct regular ride-alongs or observational assessments
- Establish formal feedback loops between EMS agencies and hospital leadership

This improves awareness and accountability for system performance.

Implement Real-Time Hospital Status and Capacity Tracking

- Utilize dashboards or regional systems to display ED capacity and wait times
- Allow EMS to make informed decisions about destination selection
- Integrate systems across counties and regions

This supports better resource allocation and reduces bottlenecks.

Optimize Emergency Department Throughput

- Increase staffing during peak times
- Expand use of fast-track or triage areas for lower-acuity patients
- Improve inpatient bed management to reduce ED boarding

While broader in scope, these improvements directly benefit EMS turnaround times.

Streamline Documentation and Administrative Processes

- Implement electronic signature capture systems
- Integrate EMS and hospital electronic records where possible
- Reduce redundant documentation requirements

Reducing administrative burden allows crews to return to service more quickly.

Establish Performance Metrics and Continuous Monitoring

- Track EMS turnaround times at each facility
- Monitor handoff delays and identify trends
- Share performance data with hospitals and EMS agencies regularly

Data-driven oversight enables targeted improvements and accountability.

Develop Regional EMS-Hospital Collaboration Committees

- Create forums for regular communication between EMS agencies and hospitals
- Review incidents, identify systemic issues, and implement corrective actions
- Encourage shared responsibility for system performance



Collaboration is essential for sustainable improvement.

Implement Offload Delay Policies and Escalation Procedures

- Define acceptable handoff time thresholds
- Establish escalation protocols when delays exceed limits
- Provide authority for EMS to transfer care under defined conditions

These policies help mitigate prolonged delays and reinforce accountability.

Explore Alternative Care and Transport Models

- Expand use of mobile integrated healthcare (MIH) programs
- Implement treat-and-release or alternative destination protocols
- Reduce unnecessary ED transports when clinically appropriate

These approaches decrease ED congestion and improve overall system efficiency.

System Status Management

System Status Management (SSM) in Emergency Medical Services (EMS) represents a data-driven approach to resource deployment that emphasizes flexibility, predictive modeling, and real-time system awareness. Rather than assigning ambulances to fixed stations, SSM dynamically positions units in areas of anticipated demand, using historical call data, temporal trends, and system status indicators to guide decisions. This approach emerged primarily in urban and suburban EMS systems seeking to improve response times while managing limited resources. By positioning units closer to predicted call locations, agencies can reduce travel distances, balance coverage, and maximize availability without increasing the number of available units. SSM is often supported by Computer-Aided Dispatch (CAD) systems and predictive analytics that identify peak demand times, high-frequency call zones, and system gaps as they develop.

At its core, SSM aims to improve response time reliability and operational efficiency. Faster responses are typically associated with improved patient outcomes. Additionally, SSM promotes system-wide equity by reducing service disparities across geographic regions. Instead of relying on static coverage that may leave some areas underserved, dynamic posting allows agencies to shift resources proactively. For high-volume systems, this can significantly reduce response delays and improve unit-hour utilization, ensuring that ambulances spend more time available for calls rather than idle at stations with low demand. When implemented effectively, SSM can also reduce the need for system expansion by enhancing existing assets.



However, the advantages of SSM must be balanced against its operational and human impacts. One of the greatest challenges to avoid is provider fatigue and job dissatisfaction. Constant movement between posting locations, limited downtime, and lack of a stable station environment can erode morale. Crew members may feel disconnected from the communities they serve, particularly when they no longer operate from a consistent local base. Another concern typically expressed is when the agency spends more time positioned outside of their primary coverage regions than within their own zones, poised to handle calls. Considerable consternation is often exhibited with the concern of funding EMS agencies to post away from their own communities or being assigned to respond to calls that are outside of those bounds. This can be especially problematic in systems that historically emphasize community integration, such as volunteer or combination departments. Additionally, excessive reliance on predictive modeling may lead to unintended service gaps if the data does not accurately account for anomalies, special events, or sudden surges in demand. Without careful oversight, SSM can create a perception of “chasing calls” rather than providing stable, community-centered coverage.

The limitations of SSM become more pronounced in rural EMS systems. Rural environments typically feature low call volumes, large coverage areas, extended transport times, and constrained staffing. In such settings, the fundamental premise of SSM, redistributing multiple available units across a demand landscape, often breaks down simply because there are too few units to reposition meaningfully. Moving a single ambulance from one area to another can create a new coverage gap rather than resolve an existing one. Furthermore, long-distance transports can tie up resources for extended periods, reducing system flexibility and limiting the effectiveness of predictive deployment. In volunteer-based or home-response systems, dynamic posting is often impractical, as personnel may respond from their homes or workplaces rather than staffed stations.

Despite these challenges, elements of SSM can still be adapted to rural and mixed-response systems in a modified form. Rather than continuous dynamic deployment, rural agencies can adopt a “low-frequency SSM” model that focuses on strategic coverage during peak demand periods. For example, historical data may reveal predictable increases in call volume during certain hours, days, or seasonal events. Agencies can use this information to temporarily reposition units, staff additional ambulances, or coordinate mutual aid coverage during these periods. Or, units can be repositioned to provide coverage over a larger geographic area when other agencies are committed, thus reducing time from dispatch to first patient contact. Similarly, regional coordination between neighboring jurisdictions can enhance system resilience without requiring constant movement of individual units. In this context, SSM becomes less about constant relocation and more about informed, deliberate decision-making.



For EMS agencies, successful implementation of SSM, whether full or modified, requires thoughtful planning and organizational alignment. Investment in robust CAD systems and data analytics tools is critical to support informed deployment decisions. Equally important is the development of clear policies governing posting practices, including limits on movement frequency, designated rest periods, and considerations for crew safety and well-being. Agencies should actively engage field personnel in the planning process to address concerns and incorporate frontline perspectives. Providing amenities at posting locations, such as restrooms and climate-controlled environments, can significantly mitigate the negative impacts of mobile deployment.

Employee wellness and retention should remain central considerations in any SSM strategy. Agencies should monitor fatigue indicators, track overtime, and establish feedback mechanisms to assess crew satisfaction. Rotational assignment models, where crews alternate between posted and station-based shifts, may help balance operational efficiency with quality of life. Additionally, maintaining some level of geographic consistency such as assigning crews to specific response zones can preserve community familiarity and professional identity while still allowing flexible deployment.

For 911 dispatch centers, the role in SSM implementation is equally critical. Dispatch protocols must be aligned with deployment strategies to ensure that the closest appropriate resource is consistently identified and assigned. This requires accurate unit status tracking, real-time visibility of system coverage, and integration between CAD systems and predictive modeling tools. Telecommunicators are trained not only in call-taking and resource allocation but could also be trained in system status awareness, enabling them to make informed decisions during periods of high demand or resource scarcity. Clear communication between dispatch and field units is essential, particularly when posting changes occur or units are reassigned to different areas.

Through accurate CAD documentation, tracking response times, call processing intervals, and unit availability metrics, dispatch agencies can provide valuable feedback to EMS leadership on the effectiveness of SSM strategies. Collaborative quality improvement initiatives between EMS agencies and dispatch centers can identify trends, address inefficiencies, and refine deployment models over time. Additionally, where none exist today, dispatch policies should include contingency plans for system overload, such as tiered response protocols, mutual aid activation thresholds, and prioritization frameworks for high-acuity calls. Pre-identified staging or move-up locations can be identified as part of the PSAP GIS layers, enhancing the ability of automation within the CAD system.



System Status Management can be a powerful tool for optimizing EMS operations. Its emphasis on data-driven decision-making and flexible deployment can yield significant improvements in response times and resource utilization. However, its effectiveness is highly context-dependent, and its application in rural systems requires careful adaptation. By balancing efficiency with provider well-being, integrating appropriate technology, and fostering strong coordination between EMS agencies and dispatch centers, SSM can be implemented in a way that enhances both operational performance and community service. Thoughtful, measured adoption rather than wholesale implementation offers the greatest potential for success across diverse EMS systems.

Computer-Aided Dispatch EMS Station Orders

Defining station orders by zone within a Computer-Aided Dispatch (CAD) system is a critical strategy for organizing EMS response in a structured, predictable, and efficient manner. In this approach, geographic areas are divided into response zones, and each zone is assigned a prioritized list of units commonly referred to as a “run card” or “station order” that are dispatched in sequence based on unit availability and proximity. These station orders are typically developed using a combination of jurisdictional boundaries, travel time analysis, historical call demand, and mutual aid agreements. When a call is received, CAD automatically recommends or assigns the closest, most appropriate available unit from the predefined order, streamlining dispatch decision-making while maintaining consistency in response patterns.

One of the primary benefits of zone-based station orders is the improvement in response time reliability. By predefining which units respond to specific areas, agencies reduce variability in dispatch decisions and ensure that the most appropriate and closest resources are consistently assigned. This structure is particularly valuable in high call volume systems or regions with complex jurisdictional overlays, where manual decision-making could introduce delays or inconsistencies. Additionally, zone-based station orders support interoperability by clearly defining mutual aid relationships and backup coverage. Neighboring agencies can be integrated into secondary or tertiary positions within station orders, ensuring seamless assistance when primary units are unavailable. This promotes system-wide resilience and reduces the likelihood of uncovered areas during peak demand or extended incidents. All defined response zones should be configured with a minimum of ten EMS stations, reducing the need to assign stations ad-hoc during high volume periods.

Another significant advantage is the alignment of deployment strategy with operational planning and performance measurement. Station orders allow agencies to analyze response data more effectively by comparing actual performance against expected unit assignments. If a unit



assigned as first-due to a zone consistently fails to meet response time benchmarks, this may indicate the need for boundary adjustments, resource reallocation, or post relocation. In this way, station orders become not only an operational tool but also a quality improvement mechanism. Further, integrating zone-based orders with CAD enables automation features such as closest-unit recommendation, dynamic unit selection, and system status alerts, all of which enhance situational awareness for dispatchers and field supervisors.

Despite these benefits, there are potential risks and limitations associated with rigid station order structures. One concern is that overly static zone assignments may not reflect real-time conditions such as traffic congestion, hospital turnaround delays, weather events, or simultaneous incidents. If CAD systems rely too heavily on predefined orders without incorporating real-time GPS tracking or dynamic travel time calculations, the “closest” unit on paper may not actually be the fastest to arrive. This can lead to suboptimal response decisions and degraded performance. Strict adherence to station orders should not replace dispatcher flexibility in decision making, particularly in complex or rapidly evolving situations where deviation from the standard assignments may be warranted.

Another potential issue is the creation of workload imbalances among units and crews. If certain zones generate disproportionately high call volumes, the units assigned as first or second due in those areas experience significantly higher utilization rates than others. Over time, this can contribute to crew fatigue, burnout, and inequities in workload distribution. Without periodic review and adjustment, station orders can unintentionally reinforce these imbalances rather than mitigate them. Similarly, in systems with limited resources zone-based station orders may offer limited benefit if there are too few units to meaningfully differentiate coverage. In such cases, a simplified or hybrid approach that incorporates elements of closest-unit dispatch and regional coverage may be more appropriate.

To maximize effectiveness while minimizing risk, EMS agencies should approach station order development as a dynamic and iterative process. Regular review of zone boundaries, call density, and response performance is essential to ensure that station orders remain aligned with current system realities. Incorporating GIS mapping and travel time modeling can improve the accuracy of zone design and unit prioritization. Agencies should also allow for controlled flexibility within CAD protocols, enabling dispatchers and supervisors to override station orders when justified by real-time conditions. Clear policies and training are critical to ensure that such deviations are applied consistently and appropriately.

CAD systems should be configured to integrate real-time unit status, GPS location data, and automatic vehicle location (AVL) capabilities to enhance decision support beyond static run



cards. Ongoing communication between dispatch and EMS leadership is essential to address identified issues, refine station orders, and ensure that the system continues to meet operational goals.

Defining station orders by zone is a proven and widely used method for organizing EMS response within CAD systems. It offers clear advantages in consistency, efficiency, and system coordination, particularly when combined with data-driven planning and strong interagency collaboration. However, its effectiveness depends on maintaining flexibility, regularly updating assumptions, and balancing structure with real-time operational awareness. When implemented thoughtfully, zone-based station orders can serve as a reliable framework that supports both day-to-day operations and long-term system improvement.

Recruitment and Retention

Recruitment and retention in EMS have become defining challenges for agencies across the country. Declining volunteerism, rising call volumes, increased training requirements, and competition from hospitals and private services have created a workforce environment where agencies must be far more intentional and strategic. Effective solutions require a blend of financial incentives, workforce development, culture building, operational redesign, and community partnerships. A comprehensive approach begins with workforce development and training pathways. Agencies can dramatically increase recruitment by removing financial barriers to entry through tuition free EMT courses for local residents, sponsorships for paramedic school tied to service commitments, paid training academies that provide stipends, and partnerships with community colleges and technical schools. This model mirrors fire and police academies and creates a predictable pipeline of new providers. Building interest early is equally important, and programs such as EMS Explorer or Cadet initiatives, dual enrollment EMT courses for high school seniors, Career and Technical Education EMS tracks, and scholarships for students pursuing EMS careers help normalize EMS as a respected profession while strengthening community ties. Retention improves when agencies make it easy for providers to maintain credentials by offering monthly in-service training, online CEU platforms, regional training consortiums, shared instructors, and simulation-based education, all of which reduce the burden of continuing education and improve morale.

Compensation, incentives, and benefits remain central to retention. Competitive wages supported by regional benchmarking, shift differentials, longevity bonuses, sign-on and referral bonuses, and tuition reimbursement can significantly reduce turnover. Benefits packages that match or exceed those offered by hospitals including health, dental, and vision insurance, retirement plans with employer match, paid parental leave, mental health and wellness programs, and employee



assistance programs, signal long-term investment in the workforce. Flexible scheduling is another major factor, as many EMS providers leave the field due to rigid or exhausting schedules. Offering 12- or 24-hour shifts based on preference, part-time and per-diem pools, seasonal staffing options, shift-bidding systems, and regional staffing pools that reduce forced overtime can dramatically improve work-life balance, especially for volunteers balancing EMS with full-time employment.

Culture, leadership, and workplace environment also play a critical role in retention. Poor leadership is one of the most common reasons EMS providers resign, making leadership academies, conflict resolution training, mentorship programs, and clear expectations for communication and professionalism essential. Recognition and appreciation programs such as annual awards ceremonies, provider-of-the-month initiatives, public recognition, letters of appreciation, and symbolic tokens like challenge coins or service bars help providers feel valued and reinforce a sense of belonging. A powerful recruitment strategy for EMS across Pennsylvania is the use of public recognition campaigns that highlight the real faces, stories, and achievements of local providers, an approach similar to the recent “I Am 911” initiative. By showcasing EMS professionals in their own communities, these campaigns humanize the work, celebrate the dedication of frontline responders, and create a sense of pride that resonates with both current providers and potential recruits. Featuring photographs of local EMTs and paramedics, along with short narratives about their accomplishments, career paths, and personal motivations, helps residents see EMS not as an abstract service but as a profession filled with relatable, skilled individuals who make a tangible difference. This type of storytelling strengthens community connection, elevates the visibility of EMS as a respected career, and encourages new candidates, especially younger residents, to envision themselves in the role. When deployed consistently across the Commonwealth, public recognition campaigns can reinforce statewide recruitment efforts, build momentum for local agencies, and contribute to a unified message that EMS is a vital, rewarding, and community-centered profession.

Improving station culture by maintaining clean, modern facilities, comfortable sleeping quarters, updated kitchens and day rooms, fitness equipment, and zero-tolerance policies for harassment or bullying creates an environment where providers feel respected and supported.

Operational and system level strategies further strengthen recruitment and retention. Regional staffing pools allow providers to pick up shifts across multiple agencies, reduce burnout, improve coverage, and minimize forced overtime, an especially effective model in rural areas with small agencies. Deployment models that reduce fatigue, such as posting units closer to high-volume areas, using peak time staffing, implementing nurse triage or low acuity pathways, and reducing unnecessary transports, help manage workload intensity. Technology that reduces



documentation burden, modern ePCR systems, voice-to-text tools, automated fields, and standardized templates, improves job satisfaction by minimizing administrative frustration.

Volunteer recruitment and retention require tailored strategies. Incentive programs such as length of service award programs (LOSAP), property tax rebates, fuel or mileage reimbursement, uniform stipends, and free training help sustain volunteer engagement. Flexible scheduling, including shorter duty crews, hybrid respond-from-home models, online shift sign-ups, and family friendly station environments, accommodates volunteers with full-time jobs. Community engagement through open houses, CPR classes, school presentations, community events, and social media outreach increases visibility and attracts new volunteers.

Mental health, wellness, and burnout prevention are essential components of workforce sustainability. Peer support teams help providers process traumatic calls, while access to mental health professionals, trauma-informed clinicians, counseling, and critical incident stress debriefings ensure providers have the support they need. Fatigue management policies that limit consecutive hours, mandate rest periods, encourage the use of PTO, and monitor burnout indicators contribute to a healthier workforce.

Recruitment marketing and branding also play a significant role. Professional marketing campaigns that include high-quality videos, social media outreach, testimonials, recruitment booths, and partnerships with local employers help position EMS as a modern, respected profession. Targeted recruitment efforts aimed at veterans, firefighters seeking EMS certification, healthcare workers seeking field experience, college students in health sciences, retirees, and individuals seeking second careers are more efficient than broad outreach.

Regional and county level solutions can create equity and consistency across agencies. A regional training consortium reduces training costs, standardizes education, increases class availability, and improves competency. Shared human resources and recruitment infrastructure can manage job postings, conduct background checks, coordinate onboarding, and maintain applicant pools, reducing administrative burden. Regional incentive programs such as county funded EMT scholarships, regional sign-on bonuses, housing stipends, and tax incentives for volunteers help stabilize the workforce.

Innovative and emerging strategies offer additional opportunities. “Earn While You Learn” programs hire students as employees while they complete EMT training, a model that has proven successful in both urban and rural systems. Registered apprenticeships through the Department of Labor provide wage progression, structured training, and nationally recognized credentials. Career ladders that outline advancement from EMT to AEMT, paramedic, field training officer, supervisor, or specialty roles such as community paramedicine or QA/QI improve retention by



giving providers a clear future in EMS. Housing and transportation support, including on-site bunk rooms, housing stipends, and agency vehicles for long-distance commuters expand the recruitment pool in rural areas.

A strong governance and implementation framework is necessary to ensure success. A regional workforce steering committee composed of EMS chiefs, training officers, county leadership, human resources representatives, hospital partners, and educational institutions should oversee implementation, monitor workforce metrics, coordinate regional initiatives, and recommend policy changes. Performance metrics should track recruitment, retention, and operational indicators such as applicant volume, class enrollment, time-to-hire, turnover rate, average tenure, sick time usage, overtime hours, unit hour utilization, and hospital offload times. A phased implementation timeline, immediate, short-term, and long-term, ensures structured progress, beginning with recruitment marketing, wage benchmarking, and documentation improvements, followed by training sponsorships, leadership development, regional staffing pools, and volunteer incentives, and culminating in the establishment of a training consortium, expanded educational pathways, full benefits enhancements, and system redesign evaluations.

One of the most persistent structural barriers facing EMS agencies across the studied region (Cameron, Clearfield, Elk, Jefferson, McKean, and Potter Counties) is the inability to recruit and retain personnel. This challenge is driven not only by low wages and limited career pathways, but the lack of temporary, purpose-built housing options that directly support EMS workforce development. Many communities in the region have experienced long-term population decline, aging housing stock, and a shrinking labor pool. Rather than addressing general housing shortages, this strategy focuses on providing short-term accommodation for individuals who are entering EMS training programs, completing certification requirements, or relocating to the region with the intention of pursuing EMS careers. Many EMS candidates, particularly those attending multiweek EMT or paramedic courses, face significant logistical challenges when training is offered far from their home community. Temporary housing would remove a major barrier to participation by allowing trainees to stay within the region for the duration of their coursework, clinical rotations, or field internships.

Housing as an EMS Workforce Recruitment and Retention Consideration

Access to safe, affordable, and stable housing can affect the ability of EMS agencies to recruit and retain personnel, particularly in rural communities where housing availability may be limited. Individuals relocating to the region for training or employment may face additional challenges in identifying housing that is affordable, available, and reasonably located in relation to their place of employment.



Housing should therefore be considered as one component of a broader regional EMS workforce strategy. Addressing housing-related workforce barriers will require collaboration among EMS agencies, counties and municipalities, housing and community development organizations, economic development partners, workforce development organizations, educational institutions, healthcare systems, and other community stakeholders.

Potential Regional Strategies

Regional partners should evaluate housing-related barriers affecting EMS recruitment and retention and determine whether existing resources or new collaborative approaches could help address identified needs. Potential strategies may include improving awareness of available housing resources; connecting prospective and newly hired EMS personnel with existing housing programs; exploring temporary or transitional housing for individuals relocating for training or employment; identifying opportunities to use existing or underutilized housing; and considering EMS workforce needs as part of broader regional housing and community development initiatives.

Where significant needs are demonstrated, regional partners may also explore grant opportunities, public-private partnerships, employer-assisted housing strategies, or other models that have been used to address workforce housing challenges in rural communities. Any strategy should be evaluated based on demonstrated need, available resources, long-term sustainability, and the capacity and expertise of participating organizations.

Housing strategies should also recognize that the needs of EMS personnel may vary. Some individuals may require short-term assistance while completing training, clinical requirements, onboarding, or relocating to the region, while others may experience longer-term challenges related to the availability or affordability of housing near their place of employment. Understanding the nature and extent of these barriers should precede the development of any specific housing initiative.

Regional Partnerships and Resources

Existing regional organizations and resources can provide a foundation for addressing housing-related workforce barriers. The North Central Pennsylvania Regional Planning and Development Commission (NCPRPDC) has assessed regional housing needs and developed housing-related resources that may inform future strategies. Workforce Solutions for North Central PA and the PA CareerLink® system can contribute to the workforce perspective by helping identify employment-related housing barriers, communicating employer and workforce needs, connecting individuals to appropriate resources, and participating in regional partnerships.



Counties, municipalities, economic development organizations, housing and community development organizations, healthcare systems, educational institutions, employers, and other community partners may also play important roles depending on the strategy pursued. Organizations with expertise in housing development, financing, acquisition, rehabilitation, and property management should lead those aspects of any housing initiative, while workforce, education, healthcare, and EMS partners can help identify needs and connect potential workers and employers with available resources.

Building upon existing regional efforts can help avoid duplication and ensure that EMS workforce needs are incorporated into broader housing, workforce, economic development, and community development strategies.

Recommended Action

The first recommendation is to formally recognize EMS workforce housing as a regional priority. Housing insecurity and lack of affordable rental options are increasingly cited by EMS providers as barriers to recruitment. Many potential EMS workers, particularly younger individuals, new graduates, and those relocating from outside the region cannot secure housing within a reasonable commute of the agencies that need them most. This is especially true in communities where the housing stock is aging, maintained, or unavailable due to seasonal or short-term rental pressures.

Regional stakeholders should collaboratively assess the extent to which housing availability and affordability affect EMS recruitment and retention and determine which strategies, partnerships, and resources are most appropriate to address identified needs. Rather than establishing a separate EMS housing system, efforts should build upon existing regional housing, workforce, economic development, and community development initiatives whenever possible. Roles should be based on the mission, expertise, capacity, and resources of participating organizations.

Integrating EMS workforce needs into broader regional housing discussions can help ensure that housing is considered alongside training, compensation, career pathways, transportation, and other factors affecting the region's ability to recruit and retain a sustainable EMS workforce.

Training and Certification

Strengthening Pennsylvania's EMS workforce requires a comprehensive, multi-layered strategy that addresses the full continuum of workforce development from initial exposure and training access to long-term retention, professional growth, and statewide coordination. The Commonwealth's EMS system is at a critical inflection point. Rural agencies are experiencing unprecedented staffing shortages; urban agencies are losing providers to hospital systems, and



volunteerism, once the backbone of Pennsylvania EMS, is declining at a rate that threatens service reliability. To reverse these trends, Pennsylvania must adopt a coordinated approach that expands training accessibility, modernizes certification support, enhances public recognition, and establishes a statewide governance structure capable of sustaining long-term workforce development.

Expanding Training Accessibility and Reducing Financial Barriers

One of the most significant barriers to EMS workforce entry in Pennsylvania is the cost of training. EMT programs can cost several hundred to several thousand dollars, and paramedic programs often exceed \$10,000 when tuition, books, uniforms, travel, housing, and clinical requirements are included. For many prospective students, especially in rural counties, these costs are prohibitive. To address this, the Commonwealth should expand tuition free EMT programs and paramedic sponsorships, prioritizing counties with the most severe workforce shortages. These programs should be structured with service commitment agreements, ensuring that graduates remain in the region for a defined period, like the models used in fire academies, police academies, and national EMS apprenticeship programs.

Pennsylvania's Area Health Education Centers (AHECs), community colleges, and technical schools are well positioned to deliver these programs in partnership with EMS agencies and county governments. Many of these institutions already have the infrastructure to support EMS education but lack the funding to scale programs to meet regional demand. Federal funding streams, including the Workforce Innovation and Opportunity Act (WIOA), Health Resources and Services Administration (HRSA) grants, and U.S. Department of Labor apprenticeship funding, can be leveraged to support tuition, stipends, and program expansion. By coordinating these resources at the state level, Pennsylvania can create a sustainable, predictable pipeline of new EMTs and paramedics.

At the regional level, Workforce Solutions for North Central PA can help connect EMS employers and individuals with workforce development programs and resources that support recruitment, training, retention, and career advancement. Eligible individuals interested in entering or advancing within EMS occupations may access training assistance through the PA CareerLink system. WIOA Individual Training Accounts (ITAs) may help eligible participants obtain occupational skills training for in-demand occupations through improved training providers, reducing financial barriers associated with obtaining required education and credentials. Incumbent Worker Training (IWT) may also assist eligible employers with the cost of training existing employees to develop new skills, advance with a new organization, and strengthen employer competitiveness and workforce retention. Other WIOA-funded training and



work-based learning opportunities may also be available to support eligible individuals entering or advancing within EMS occupations. On-the-job training (OJT) may provide another strategy for EMS employers that hire eligible individuals who require additional occupational training to become fully proficient in the position. Through OJT, eligible employers may receive reimbursement for a portion of the participants' wages during the structured training period, helping offset the costs associated with the training. A new employee while allowing the individual to earn wages and gain skills on the job. OJT may provide a shorter-term work-based learning option for individual hires, complementing longer term workforce development strategies such as Registered Apprenticeship.

Registered Apprenticeship should also be explored as a workforce development strategy for EMS occupations. Registered Apprenticeship combines paid employment with structured on-the-job learning, related technical instruction, workplace mentoring, and progressive skill and wage advancement. This earn and learn model may help reduce financial barriers to entering EMS careers while providing employers with a structured approach to developing and retaining skilled workers. As regional apprenticeship capacity develops, EMS occupations including EMT and paramedic could be evaluated for apprenticeship development based on employer interest workforce demand, training requirements, and program feasibility.

Strengthening Early Career Pathways and High School Engagement

Early exposure to EMS is one of the strongest predictors of workforce entry. National research shows that students who encounter EMS through high school programs, explorer posts, or CTE pathways are significantly more likely to pursue EMS careers. Pennsylvania has pockets of strong high school EMS programming, but access varies widely across the Commonwealth. Rural districts often lack the funding, instructors, or partnerships needed to sustain EMT dual enrollment programs or EMS focused CTE tracks.

Existing regional career awareness resources should be leveraged to strengthen early exposure to EMS careers. Workforce Solutions for North Central PA's PA Six Careers platform provides an opportunity to increase the visibility of EMS employers and occupations and help students, job seekers, career changers, educators, and parents better understand regional career opportunities, education and training requirements, and pathways into EMS employment.

EMS agencies should be encouraged to participate in PA Six Careers and related business education activities that provide opportunities for career presentation, demonstrations, job shadows, career fairs, and other career exploration and work-based learning experiences. Connecting career awareness activities with accessible training and employment pathways can



help move individuals from initial interest in EMS to training, certification, and ultimately employment.

Partnerships with PA CareerLink and WIOA youth programs should also be explored to create opportunities for eligible young people to gain exposure to EMS and healthcare careers through career exploration, work experience, Work based learning and connections to occupational training. These strategies can complement school-based career awareness efforts and provide a bridge between initial career interest to training and employment.

To address this disparity, Pennsylvania should standardize and expand early career EMS pathways statewide. This includes strengthening CTE EMS programs, expanding dual enrollment EMT courses for high school seniors, and supporting explorer and cadet programs that introduce students to EMS through hands-on experiences. These initiatives not only build interest but also normalize EMS as a respected profession, countering the perception that EMS is a temporary or transitional job. Integrating EMS career awareness into statewide workforce development initiatives such as PA CareerLink, Future Ready PA, and the Pennsylvania Workforce Development Board, would further reinforce EMS as a viable and essential career path.

Improving Continuing Education and Recertification Processes

Retention is closely tied to the ease with which providers can maintain their credentials. Pennsylvania's EMS providers must meet continuing education requirements aligned with NREMT standards, but access to high-quality CEU opportunities varies significantly by region. Rural providers often travel long distances for in-person training, and many agencies lack the resources to offer structured in-service programs. This creates a burden that contributes to burnout and turnover.

To address this, the Commonwealth should support the creation of regional training consortiums that pool instructors, simulation resources, and CEU offerings across multiple agencies. States such as North Carolina and Minnesota have successfully implemented regional training hubs that reduce costs, improve provider competency, and ensure consistent educational quality. Pennsylvania's existing EMS regional councils, including North Central, South Central, Eastern PA, and others are natural anchors for these consortiums. By coordinating training at the regional level, the Commonwealth can ensure that providers have equitable access to high-quality continuing education regardless of geography.

Additionally, agencies should adopt modern ePCR systems, voice-to-text documentation tools, and standardized templates to reduce administrative burden. Documentation is one of the most



frequently cited sources of frustration among EMS providers, and reducing this burden frees up time for training, professional development, and rest. Modernizing documentation systems also aligns Pennsylvania with national data standards established by NEMSIS, improving the Commonwealth's ability to analyze workforce trends and clinical outcomes.

A coordinated EMS workforce strategy should address the full career pathway from career awareness and recruitment through training, employment, retention, and advancement. PA Six Careers can support early career awareness and employer engagement; Registered Apprenticeship and other work-based learning strategies can provide structured pathways into and through EMS occupations; and incumbent worker training can support continued skill development and advancement of the existing workforce. Leveraging these resources in coordination with EMS agencies, educational institutions, county and municipal partners, and the PA CareerLink system can help build a stronger and more sustainable regional EMS workforce pipeline.

Integrating Public Recognition into Recruitment and Workforce Development

Public recognition is a powerful but underutilized recruitment tool. Pennsylvania's recent "I Am 911" campaign demonstrated the impact of storytelling-based recruitment by highlighting the real faces, stories, and achievements of local EMS providers. These campaigns humanize the profession, celebrate the dedication of frontline responders, and create a sense of pride that resonates with both current providers and potential recruits.

Expanding this approach statewide would allow Pennsylvania to build a unified recruitment identity. Campaigns should feature photographs of local EMTs and paramedics, along with narratives about their accomplishments, motivations, and career paths. These stories help residents see EMS not as an abstract service but as a profession filled with relatable, skilled individuals who make a tangible difference in their communities. Nationally, states such as Oregon and Virginia have seen increased interest in EMS careers after implementing similar campaigns. Pennsylvania can build on this momentum by coordinating public recognition efforts through the Department of Health, regional EMS councils, and local agencies, ensuring consistent messaging and broad visibility.

Establishing a Statewide Governance and Implementation Framework

A long-term solution to Pennsylvania's EMS workforce challenges requires a coordinated governance structure capable of overseeing recruitment, training, certification, and retention efforts across the Commonwealth. Currently, workforce initiatives are fragmented, with individual agencies and counties pursuing their own strategies without a unified statewide plan.



To address this, Pennsylvania should establish a statewide EMS workforce steering committee composed of EMS leaders, county officials, training officers, HR representatives, hospital partners, and educational institutions.

This committee would be responsible for monitoring workforce metrics, coordinating recruitment campaigns, evaluating training programs, and recommending policy changes. It would also ensure that workforce initiatives are data driven, sustainable, and responsive to regional needs. Performance metrics should include applicant volume, class enrollment, time-to-hire, turnover rates, average tenure, sick time usage, overtime hours, unit hour utilization, and hospital offload times. By tracking these indicators, the Commonwealth can identify emerging workforce challenges and adjust strategies accordingly.

A phased implementation timeline, beginning with immediate actions such as recruitment marketing and wage benchmarking, followed by shorter initiatives like training sponsorships and regional staffing pools, and culminating in long-term system redesign, will ensure structured progress. This approach aligns Pennsylvania with national best practices and positions the Commonwealth as a leader in EMS workforce innovation.

By investing in training accessibility, certification support, early career pathways, public recognition, and coordinated governance, Pennsylvania can build a resilient EMS workforce capable of meeting the Commonwealth's emergency medical needs for decades to come. These strategies not only address immediate workforce shortages but also lay the foundation for a sustainable, professionalized EMS system that attracts, develops, and retains high-quality providers. The challenges facing Pennsylvania EMS are significant, but with a comprehensive, statewide approach, the Commonwealth can strengthen its EMS infrastructure and ensure that every community, urban, suburban, and rural, has access to reliable, high-quality emergency medical care.



EMS Authority

Across Pennsylvania, many EMS systems are facing similar challenges: increasing call volumes, workforce shortages, rising operational costs, declining volunteer participation, and growing expectations for service delivery. As communities look for solutions, one option that has gained attention is the creation of a regional EMS authority. While Pennsylvania's EMS laws do not specifically require the establishment of EMS authorities, the Commonwealth's Emergency Medical Services System Act strongly supports coordinated, regional approaches to EMS planning and delivery, making an authority model a practical option for interested municipalities, counties, and healthcare partners.

At its core, an EMS authority is simply an organization created to oversee and coordinate emergency medical services across a defined area. Rather than having multiple municipalities or agencies independently addressing EMS challenges, an authority can provide centralized leadership, planning, funding, and oversight. The goal is not necessarily to eliminate existing EMS agencies, but to create a structure that helps communities work together toward common objectives such as improving service reliability, strengthening finances, supporting workforce development, and ensuring consistent patient care. These objectives align closely with Pennsylvania's stated policy that emergency medical services are an essential public service and should be delivered through a regulated and coordinated system.

An EMS authority can take many forms depending on local needs. In some areas, it may function primarily as a planning and administrative organization while existing EMS agencies continue to operate independently. In other situations, it may directly manage ambulance operations, staffing, billing, fleet management, and deployment decisions. The structure should be tailored to the needs of the participating municipalities and stakeholders. Regardless of the model selected, the authority would continue to operate within Pennsylvania Department of Health regulations governing EMS agencies, personnel, vehicles, medical oversight, and system operations.

The primary reason communities consider an EMS authority is sustainability. Many local governments are discovering that the traditional EMS models that served them for decades are becoming increasingly difficult to maintain. Recruiting volunteers has become more challenging, labor and equipment costs continue to increase, and reimbursement often does not cover the actual cost of providing emergency medical care. By creating a regional authority, communities may be able to share resources, reduce duplication, improve efficiency, and establish a more stable funding structure.

An authority can also help improve coordination among EMS agencies, hospitals, public safety answering points (911 centers), emergency management organizations, and local governments.



Instead of each organization making decisions independently, the authority can establish common goals, performance standards, and operational expectations. This can lead to more consistent service across municipal boundaries and improved system performance overall.

For municipalities, healthcare systems, or EMS agencies interested in exploring an EMS authority, the process begins with a system assessment, which has been completed with this study.

The study of the six-county region included an evaluation of call volumes, response times, staffing levels, financial performance, workforce trends, station locations, vehicle utilization, and mutual aid activity. Multiple sources of data and information were collected from EMS agencies, county communications centers, training facilities, and regional EMS councils; all provided valuable insights during this phase. Pennsylvania's EMS framework places significant emphasis on planning and data-driven decision making, making this a critical starting point.

The EMS study is complete, and interested parties can begin stakeholder discussions. This phase should involve municipal officials, EMS leaders, hospital representatives, county officials, emergency management personnel, and community members. Early conversations should focus on identifying common concerns and determining whether a regional approach could address those issues more effectively than individual agency efforts. The objective is to build consensus around a shared vision for the future of EMS service within the region.

The next step is developing a governance model. This includes deciding what the authority would do, who would oversee it, how decisions would be made, and how participating entities would be represented. Most successful authorities utilize governing boards that include representation from municipalities, healthcare organizations, public safety agencies, and community stakeholders. The governance structure should balance regional coordination with local input, ensuring that communities continue to have a voice in EMS system decisions.

After governance is established, stakeholders can focus on operational planning. Questions that need to be addressed include:

- Will the authority directly operate ambulances?
- Will existing EMS agencies remain independent?
- How will staffing be managed?
- How will stations and vehicles be deployed?
- What level of service is expected throughout the region?
- How will performance be measured?



Responses to the above questions may vary depending on local conditions, but the planning process should always align with Pennsylvania EMS licensing requirements and operational regulations.

Funding discussions typically occur alongside operational planning. An EMS authority should develop a long-term financial plan rather than relying only on ambulance transport revenue. Potential funding sources may include municipal contributions, service contracts, grants, EMS operating fund opportunities, healthcare partnerships, and revenue generated through EMS operations. The objective is to create a diversified funding model that can withstand fluctuations in reimbursement and service demand.

A financial analysis should also identify opportunities for cost savings through regionalization. Cooperative purchasing, centralized administration, common training programs, fleet standardization, and coordinated deployment may all generate efficiencies that help reduce overall operational costs. While an authority is not guaranteed to save money, it can provide greater financial predictability and stability.

An EMS authority should place significant emphasis on clinical quality. Pennsylvania requires licensed EMS agencies to operate under medical direction and to follow statewide EMS protocols established by the Department of Health. An authority can support these requirements by coordinating medical oversight, quality assurance activities, continuing education efforts, and clinical performance reviews across the entire region.

This approach helps ensure that patients receive a consistent level of care regardless of which ambulance responds. It also creates opportunities to track key performance indicators such as cardiac arrest survival, trauma outcomes, pain management effectiveness, and overall compliance with statewide protocols.

Once a governance structure, operational plan, and financial model have been developed, participating entities can move toward formal implementation. Depending on the structure selected, this may involve intergovernmental agreements, creation of a new legal entity, transfer of assets, execution of service agreements, and licensure activities consistent with Pennsylvania EMS regulations. Initial implementation is often phased to allow stakeholders to evaluate progress and make adjustments, as necessary.

Even after implementation, the work of an EMS authority is never truly finished. Ongoing evaluation, system monitoring, workforce development, strategic planning, and stakeholder engagement are necessary to ensure the authority remains responsive to changing community



needs. The most successful EMS authorities will continue to evolve and focus on continuous improvement and long-term sustainability.

An EMS authority is not an all-encompassing solution, nor is it intended to replace the important contributions of local EMS agencies and municipal governments. Instead, it is a tool that communities can use to strengthen regional coordination, improve financial stability, support workforce development, and ensure that high-quality emergency medical care remains available for future generations. For Pennsylvania communities facing increasing EMS challenges, an authority model may provide a structured pathway toward a more sustainable and integrated emergency medical services system.

Mobile Integrated Healthcare / Community Paramedicine (MIH-CP)

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) represent an innovative evolution of emergency medical services that expands the role of EMS providers beyond traditional emergency response and transport. Instead of functioning primarily as a transport-based system focused on getting patients to the emergency department, MIH-CP programs are designed to deliver the right care, at the right time, in the right setting, often outside of hospitals. These programs combine EMS, public health, primary care, and social services into a coordinated model that addresses both acute medical needs and underlying drivers of healthcare utilization, especially in underserved and rural communities.

At its core, MIH-CP shifts EMS from a reactive model to a proactive, patient-centered system. Community paramedics and specially trained EMS clinicians provide in-home assessments, chronic disease monitoring, post-discharge follow-ups, medication reconciliation, and referrals to appropriate care providers such as primary care physicians, mental health services, or social support agencies. As an alternative to automatically transporting every patient to the hospital, MIH clinicians assess whether a patient can be safely treated on scene, referred to another care setting, or monitored over time. This approach significantly reduces unnecessary emergency department visits while improving patient outcomes and satisfaction.

MIH-CP programs operate through a combination of scheduled and unscheduled care pathways. Scheduled services include post-hospital discharge visits, wellness checks, chronic disease management, and follow-ups for frequent EMS users. These visits are typically coordinated with hospitals or healthcare systems to prevent readmissions and ensure continuity of care. Unscheduled services often occur when 911 is activated, but instead of default transport to the



emergency department, patients may receive treatment on scene or be directed to alternative care options.

A key component of MIH-CP is the integration of telehealth technology, which allows field providers to consult in real time with physicians, nurse practitioners, or specialists. This expands the clinical capabilities of EMS crews in the field and supports more informed decision-making regarding treatment and disposition. For example, a patient experiencing a minor infection or medication issue can be evaluated in coordination with a physician remotely, avoiding unnecessary ambulance transport and emergency department visit.

Another critical element is care coordination and navigation. MIH programs often focus on patients who frequently call 911 due to chronic illness, behavioral health needs, or lack of access to primary care. By connecting these patients with appropriate resources and addressing root causes such as medication non-compliance, housing instability, or lack of transportation, MIH programs reduce repeated EMS use and improve overall health outcomes.

The benefits of MIH-CP are especially significant in rural areas, where healthcare access is limited, hospitals are often far from patients, and EMS resources are already strained. One of the primary advantages is improved system availability. In traditional EMS systems, units can be tied up for extended periods transporting low-acuity patients to distant hospitals and waiting for patient offload. MIH-CP reduces these unnecessary transports, allowing ambulances to remain available for true emergencies and improving response times across the system.

Rural communities also face challenges related to provider shortages and hospital capacity. Many patients rely on EMS as their primary point of healthcare access. MIH-CP fills this gap by bringing healthcare directly into the community, effectively extending the reach of physicians and healthcare systems. This is particularly important for managing chronic diseases, which are prevalent in rural populations and often lead to repeated emergency department visits when not properly controlled.

Additionally, MIH-CP enhances patient outcomes and satisfaction. Patients receive care in their homes or communities, which is often more convenient and less stressful than visiting an emergency department. This approach is particularly beneficial for elderly patients, individuals with mobility limitations, and those with behavioral health needs who may not benefit from an ED environment.

One of the most compelling aspects of MIH-CP is its potential to generate significant cost savings for healthcare systems and communities. Emergency department visits and hospital admissions are among the most expensive components of the healthcare system. By reducing



unnecessary transports and admissions, MIH-CP programs can lower overall healthcare expenditures.

Cost savings are realized in several ways. First, avoiding unnecessary ambulance transports and ED visits reduces direct costs to patients, insurers, and healthcare systems. Second, MIH programs help decrease hospital readmissions. Third, proactive management of chronic conditions reduces the likelihood of costly emergency interventions.

From an EMS perspective, MIH-CP can also improve financial sustainability. Traditional EMS reimbursement models are heavily dependent on transport revenue, which incentivizes unnecessary transports. MIH-CP programs introduce alternative funding streams, including grants, healthcare partnerships, and value-based reimbursement models tied to improved patient outcomes and reduced utilization.

Possibly the most important system-level benefit of MIH-CP is its ability to preserve EMS and hospital capacity. When ambulances are tied up on non-emergency transports or delayed at hospitals due to overcrowding, the entire EMS system becomes less effective. MIH-CP reduces system strain by ensuring that only patients who truly need emergency care are transported to hospitals.

This has a cascading effect across the healthcare system. Emergency departments experience lower patient volumes for non-urgent conditions, reducing crowding, and improving throughput for critical patients. EMS units spend less time at hospitals and more time available for response, improving coverage and response reliability, particularly in rural areas where resources are limited.

In February 2026, the Meadville Central Fire Department was awarded \$1.2 million in federal funding to develop a mobile integrated health program. The funding is intended to support paramedic training, telehealth implementation, and the development of alternative care pathways designed to reduce unnecessary ambulance transports and emergency department utilization.

The program specifically aims to address a common EMS challenge: a significant number of calls involve patients who do not require emergency department care but currently have no alternative options. The intent is to expand clinical capabilities and integrating telehealth, to treat or refer patients more appropriately, improving patient care while conserving EMS and hospital resources. This initiative reflects a broader national trend toward adopting MIH-CP as a solution to rising EMS demand, workforce shortages, and healthcare system inefficiencies.

To successfully implement MIH-CP, EMS agencies should focus on several key elements aligned with Pennsylvania and national standards. First, strong partnerships with hospitals,



primary care providers, and public health agencies are essential for care coordination and sustainability. Second, agencies must invest in training and credentialing, ensuring that providers have the skills required for expanded clinical roles. Third, robust data collection and performance measurement are critical for demonstrating outcomes, securing funding, and refining program operations.

Finally, regulatory alignment is important. Pennsylvania has increasingly supported community paramedicine initiatives, but agencies must ensure compliance with state protocols, medical direction requirements, and reimbursement policies. As healthcare moves toward value-based care models, MIH-CP programs are well positioned to play a central role in improving outcomes while controlling costs.

Mobile Integrated Healthcare and Community Paramedicine represent a transformative shift in how EMS systems deliver care. By expanding the role of EMS providers, integrating technology such as telehealth, and focusing on patient-centered, preventative care, MIH-CP programs address many of the challenges facing rural EMS systems today. These programs not only reduce unnecessary transports and healthcare costs but also improve patient outcomes, enhance system efficiency, and ensure that EMS and hospital resources remain available for those who need them most. The recent investment in Meadville demonstrates that this model is gaining momentum and offers a promising path forward for rural communities across Pennsylvania and beyond.

Workforce Solutions for North Central Pennsylvania (WSP) could play a critical and highly strategic role in supporting the development and long-term sustainability of Mobile Integrated Healthcare–Community Paramedicine (MIH-CP) programs across the studied region. Because MIH-CP is fundamentally a workforce-driven model, relying on expanded clinical roles, interdisciplinary coordination, and new care delivery approaches, regional workforce agencies are uniquely positioned to address many of the barriers that rural EMS providers face when trying to implement these programs.

One of the most important contributions WSP could make is in workforce development and training pipeline expansion. MIH-CP requires EMS clinicians who are trained beyond traditional EMT or paramedic roles, including skills in chronic disease management, patient education, behavioral health awareness, and care coordination. Workforce Solutions could partner with local EMS agencies, community colleges, and training institutions to develop targeted education programs that support community paramedic certification, telehealth competency, and advanced clinical decision-making. This would help standardize training across the region and ensure providers are equipped to safely deliver expanded services in patients' homes. Additionally,



WSP could help subsidize training costs, provide tuition assistance, or leverage grant funding to increase participation among rural providers who may otherwise be unable to afford additional certifications.

Another key area is recruitment and retention, which is a persistent challenge in rural EMS systems. MIH-CP programs can serve as a powerful recruitment tool by offering career advancement opportunities, expanded scope of practice, and more diverse work experiences compared to traditional EMS roles. Workforce Solutions could help promote EMS careers as part of a broader healthcare pathway, connecting high school students, career changers, and displaced workers to EMS and MIH-CP roles. This might include developing career ladders (EMT → paramedic → community paramedic), apprenticeship programs, or “earn while you learn” models that reduce barriers to entry. Retention efforts could focus on improving job satisfaction by supporting flexible scheduling, reducing burnout through lower transport workloads, and creating specialized MIH positions that allow providers to work in preventative and community-based care rather than exclusively emergency response.

Workforce Solutions could also play a major role in facilitating partnerships across the healthcare system, which are essential for MIH-CP success. MIH programs require coordination among EMS agencies, hospitals, primary care providers, behavioral health services, and social service organizations. WSP could act as a regional convener, helping to align these stakeholders and identify workforce gaps across the continuum of care. For example, they could assist in developing shared staffing models for care coordinators, telehealth support personnel, or case managers who work alongside EMS providers. This type of regional coordination is particularly valuable in rural areas where resources are limited, and collaboration is necessary to achieve scale.

In addition, Workforce Solutions could support grant development and funding alignment, which is critical for launching MIH-CP initiatives. Many MIH programs rely on startup funding from federal, state, or private grants, such as the February 2026 award of \$1.2 million to the Meadville Central Fire Department to develop a mobile integrated health program focused on paramedic training, telehealth expansion, and reducing unnecessary emergency department transports. Workforce agencies often have expertise in identifying funding opportunities and can help EMS agencies develop competitive applications, align programs with workforce priorities, and demonstrate economic impact such as job creation, healthcare cost reduction, and improved access to care.

Another significant contribution is in data analysis and labor market intelligence. MIH-CP programs must demonstrate value through measurable outcomes such as reduced hospital



admissions, decreased EMS utilization by frequent callers, and improved patient outcomes. Workforce Solutions can provide regional data on workforce supply and demand, healthcare utilization trends, and population health indicators. This information can help EMS agencies design MIH programs that target the most impactful populations, such as high utilizers, patients with chronic conditions, or underserved rural residents. It also strengthens the case for continued funding by demonstrating both clinical and economic benefits.

Workforce Solutions could further assist by supporting the development of new job roles and interdisciplinary positions that are essential to MIH-CP. These may include community paramedics, care coordinators, patient navigators, and telehealth technicians. By helping define job descriptions, competencies, and credentialing pathways, WSP can ensure that these roles are recognized within the regional workforce system and aligned with employer needs. This is particularly important as MIH-CP evolves, since many of these roles fall outside traditional EMS job classifications.

From a broader system perspective, WSP can help advance healthcare system efficiency and cost containment, which are central goals of MIH-CP. By reducing unnecessary ambulance transports and emergency department visits, MIH programs free up EMS units and hospital resources for higher-acuity patients. Quantifying these system benefits in economic terms, showing how MIH-CP contributes to regional healthcare sustainability, reduces costs, and supports workforce stability across EMS and hospital systems.

Finally, Workforce Solutions could play a leadership role in regional planning and long-term sustainability of MIH-CP programs. Rural EMS agencies often lack the administrative capacity to develop and sustain complex programs independently. WSP can provide strategic planning support, facilitate regional collaboration among multiple agencies, and help build scalable models that serve multiple counties. This is especially important in areas like north central Pennsylvania, where geographic dispersion and limited resources make regional approaches more effective than isolated agency-level efforts.

In summary, Workforce Solutions of North Central Pennsylvania could significantly enhance the success of MIH-CP initiatives by strengthening the EMS workforce pipeline, supporting training and certification, improving recruitment and retention, fostering healthcare partnerships, assisting with funding and data analysis, and helping develop new roles aligned with modern EMS practice. By aligning workforce development with healthcare innovation, WSP can help ensure that MIH-CP programs not only launch successfully but remain sustainable, scalable, and impactful in improving access to care and system efficiency across rural communities.



Nurse Navigator – ECNS - Lowcode

Nurse line triage programs, whether branded as “Nurse Navigation,” “Nurse Triage,” or integrated into LowCode/Low-Acuity dispatch pathways, represent one of the most significant operational shifts in modern 911 systems. At their core, these models insert a clinically trained nurse into the call-taking workflow for low acuity incidents, allowing a secondary triage layer that can more accurately determine whether an ambulance is truly required. For PSAPs, this can reduce call processing congestion, improve prioritization of high acuity events, and create a more nuanced disposition pathway than the traditional binary of “dispatch or don’t dispatch.” When implemented well, nurse triage can help PSAPs maintain service levels even during periods of high demand by diverting non-emergent callers away from the emergency response queue.

Not Every Emergency Needs an Ambulance

Research shows that 15-20% of medical calls coming into Emergency Communications Centers can be referred to a secondary nurse triage system. Without a system in place to triage them, these low-acuity, non-emergency calls can consume valuable time and resources that are needed for more urgent situations. ECNS gives MPDS Accredited Centers new options to care for patients who do not require an ambulance or a trip to the ER. Over 200 protocols help assess and assign appropriate care to patients over the phone, resulting in better patient outcomes while decreasing the burden on First Responders and emergency health care providers.

Priority Dispatch - ECNS

For EMS agencies, the impact is more operationally tangible. By filtering out low-acuity calls that do not require an ambulance, nurse triage programs can meaningfully improve ambulance availability. Every avoided transport frees up a unit that would otherwise be tied up for one to two hours on a call that provides little clinical value. In systems facing long hospital turnaround times, staffing shortages, or rural geography, this can translate into measurable improvements in response times for time sensitive emergencies. Some programs also coordinate alternative transportation, rideshare, wheelchair vans, or scheduled clinic visits, which further reduces unnecessary EMS utilization. However, the success of these alternatives depends heavily on local infrastructure, availability of transportation vendors, and the reliability of follow-up care options.

From a patient-care perspective, the evidence is mixed but generally positive when programs are tightly governed. Nurse triage can maintain or even improve patient outcomes for low acuity



callers by directing them to more appropriate care settings, urgent care, telemedicine, primary care, or home self-care instructions. Many callers benefit from immediate clinical advice rather than waiting for an ambulance that ultimately cannot provide definitive treatment. That said, the inherent risk lies in mis-triage. If a patient with subtle but serious symptoms is incorrectly categorized as low acuity, the delay in EMS response could worsen outcomes. This risk is mitigated through strict protocols, continuous QA/QI review, and the ability for nurses to escalate back to 911 dispatch at any point.

There are also system level risks that PSAPs and EMS leaders must acknowledge. Nurse triage introduces additional handoffs, which can create communication gaps if workflows are not seamless. It also requires strong public messaging; callers must trust that being diverted to a nurse is not a denial of service. Additionally, alternative transportation solutions may fail, rideshare cancellations, long wait times, or lack of wheelchair accessible vehicles, forcing EMS to respond anyway and negating the intended efficiency gains. In rural areas, where healthcare access is already limited, nurse triage may highlight gaps in the system that cannot be solved simply by diverting calls.

Overall, nurse triage and LowCode pathways can significantly improve ambulance availability and reduce strain on 911 centers, but only when implemented with rigorous clinical oversight, strong operational integration, and continuous monitoring of patient outcomes. They are not a universal fix, and they do not eliminate the need for robust EMS resources. Instead, they function as a strategic pressure relief valve, one that can preserve EMS capacity for true emergencies while still ensuring that low acuity patients receive safe, appropriate, and timely care.

This model fundamentally shifts the traditional 911 workflow from a “dispatch first” approach to a more clinically informed decision tree. For PSAPs and EMS agencies facing staffing shortages, rising call volumes, and long hospital turnaround times, this represents a strategic tool to preserve emergency resources for time critical incidents.

For PSAPs, nurse triage and LowCode pathways provide a meaningful operational advantage by reducing the burden of low acuity calls on call-takers and dispatchers. When non-emergent callers are transferred to a nurse for secondary clinical review, call-takers can remain focused on high-priority incidents that require rapid processing and dispatch. This improves overall call-handling efficiency and helps ensure that true emergencies receive immediate attention. The presence of a clinical professional in the workflow also enhances prioritization by adding a layer of medical judgment that traditional scripted protocols cannot fully replicate. Many callers experience improved satisfaction because they receive real-time clinical advice rather than waiting for an ambulance that may not be necessary. For PSAP leadership, these programs offer



a strategic tool to stabilize operations, manage rising call volumes, and maintain service levels without proportionally increasing staffing or infrastructure.

For EMS agencies, the impact of nurse triage is most visible in improved ambulance availability and more efficient use of limited resources. By diverting low acuity calls away from automatic ambulance dispatch, agencies can significantly reduce the number of units tied up on non-emergent transports that often consume an hour or more of operational time. This reduction in unnecessary responses directly increases the number of ambulances available for high acuity emergencies, improving response times, and system reliability. In communities facing staffing shortages, long hospital turnaround times, or geographic challenges, this increased availability can be critical. Additionally, when nurse triage programs coordinate alternative transportation such as rideshare, wheelchair vans, or scheduled clinic visits, ambulances remain in service for true emergencies rather than being committed as default transport for minor issues. Over time, this can reduce crew fatigue, lower overtime costs, and support more sustainable deployment models.

From a patient-care perspective, nurse triage can enhance the quality and appropriateness of care for low acuity callers. Instead of being automatically routed into the EMS and emergency department pipeline, patients receive immediate clinical guidance from a licensed nurse who can assess their symptoms in greater detail. This often results in more appropriate care pathways, such as urgent care, telemedicine, primary care follow-up, or safe self-care at home. Patients avoid unnecessary ambulance transport and emergency department visits, which reduce costs, minimize exposure to crowded ED environments, and often lead to faster access to the type of care they actually need. For individuals with chronic or recurring issues, nurse triage can provide tailored advice that EMS crews are not positioned to deliver during a brief on scene encounter. When supported by strong clinical oversight and quality assurance, these programs maintain or even improve patient outcomes while reducing strain on emergency systems.



Collaborative Billing

Enhanced EMS billing and collaborative billing models have emerged as essential strategies for stabilizing emergency medical services in an era of rising operational costs, declining volunteerism, and increasingly complex reimbursement environments. As counties and multi-county regions explore consolidation, shared services, or regionalized EMS authorities, billing is one of the most impactful and often overlooked areas where collaboration can yield immediate financial and operational benefits. By pooling billing functions, negotiating as a larger entity, and standardizing documentation and throughput, EMS agencies can retain a greater percentage of their invoiced fees, reduce administrative overhead, and improve revenue predictability. At the same time, collaborative billing introduces new governance, data-sharing, and compliance considerations that must be carefully managed. The following analysis explores the opportunities, risks, and strategic considerations associated with enhanced and collaborative EMS billing, including the potential to invoice out-of-county patients a standardized stipend to support Quick Response Services (QRS), training, supplies, and capital needs.

Enhanced EMS billing refers to a set of practices that improve the accuracy, completeness, and timeliness of EMS claims. These practices include improved documentation, real-time data capture, automated coding, payer specific optimization, and proactive denial management. For many EMS agencies, especially those operating independently billing is often fragmented, inconsistent, or outsourced to vendors who lack EMS specific expertise. Enhanced billing seeks to correct these inefficiencies by applying standardized processes and leveraging technology to maximize allowable reimbursement.

The financial impact of enhanced billing is significant. Studies across multiple states have shown that EMS agencies lose between 10% and 25% of potential revenue due to incomplete documentation, coding errors, or failure to pursue secondary payers. Enhanced billing practices can reduce these losses by ensuring that every billable service is captured, every claim is coded correctly, and every payer is pursued to the fullest extent allowed by law. For agencies already struggling with staffing shortages, rising costs, and increased call volume, recovering even a fraction of this lost revenue can be transformative.

Enhanced billing also improves transparency and accountability. By centralizing data and applying consistent metrics, agencies can better understand their payer mix, denial rates, average revenue per transport, and trends in uncompensated care. This information is critical for strategic planning, grant applications, and discussions with municipal leaders about funding needs. In many cases, enhanced billing becomes the foundation upon which broader regional collaboration is built.



Collaborative Billing Across a County or Multi-County Region

Collaborative billing takes enhanced billing a step further by pooling billing functions across multiple EMS agencies within a county or region. This model can take several forms:

- A vendor serving all countywide EMS agencies.
- A vendor serving regional billing spanning multiple counties.
- A billing division within a regional EMS authority.
- A shared-services agreement where one agency provides billing for others.
- A third-party vendor contracted collectively by multiple agencies.

Regardless of structure, the goal is the same: to leverage economies of scale, standardize processes, and negotiate from a position of strength.

Economies of Scale and Cost Reduction

Billing is fundamentally a volume-driven activity. The more claims processed, the lower the cost per claim. When agencies collaborate, they can reduce costs in several ways:

- Shared staffing reduces the need for each agency to employ its own billing personnel.
- Shared software licenses lower per-agency costs for ePCR systems, clearinghouses, and billing platforms.
- Shared training ensures consistent documentation and coding practices.
- Shared compliance resources reduce the risk of HIPAA violations or audit findings.
- Shared quality assurance improves documentation completeness and reduces denials.

A countywide or regional billing office can reduce administrative costs by 20% to 40% compared to each agency operating independently. These savings can be reinvested into staffing, equipment, or capital needs.

Large-Scale Negotiation Power

One of the most significant advantages of collaborative billing is the ability to negotiate as a larger entity. Payers, especially commercial insurers, respond differently when negotiating with a single small EMS agency versus a regional EMS authority representing tens of thousands of annual transports.

Large-scale negotiation can influence:

- Reimbursement rates for ALS, BLS, SCT, and mileage.
- Timeliness of payments and reduction of administrative burdens.



- Preferred provider agreements that guarantee payment levels.
- Resolution of chronic denial patterns.
- Access to payer specific portals and tools.

A regional entity processing 20,000 transports per year has far more leverage than an individual agency processing 1,000 transports. This leverage translates directly into higher net revenue.

Increased Throughput and Faster Cash Flow

The speed at which claims move from incident to payment is a critical determinant of financial stability. Collaborative billing improves throughput by:

- Standardizing documentation requirements.
- Reducing delays caused by incomplete PCRs.
- Automating claim submission and follow-up.
- Applying consistent denial management practices.
- Ensuring that claims are submitted within optimal timeframes.

Faster throughput improves cash flow, reduces the need for short-term borrowing, and stabilizes agency finances. For agencies operating on thin margins, improved cash flow can be the difference between sustainability and collapse.

Beyond cost savings and increased revenue, collaborative billing offers several strategic advantages.

Standardized Documentation and Training

A regional billing model requires standardized documentation practices across all participating agencies. This standardization improves:

- Clinical documentation quality.
- Compliance with state and federal regulations.
- Data accuracy for the National Medical Services Information System (NEMSIS) reporting.
- Interoperability between agencies.
- Training consistency for EMTs and paramedics.

Standardization also reduces the burden on providers, who no longer need to navigate multiple documentation expectations depending on which agency they are working for.

Improved Data Analytics and System Planning



A regional billing office becomes a central repository for EMS data. This data can be used to:

- Identify call volume trends.
- Analyze payer mix and reimbursement patterns.
- Support grant applications.
- Inform deployment models and staffing plans.
- Evaluate the financial impact of hospital closures or service changes.
- Support countywide or regional EMS strategic planning.

When data is fragmented across multiple agencies, these insights are difficult to obtain.

Collaborative billing unlocks the ability to plan EMS systems holistically.

Strengthened Regional Identity and Collaboration

Billing collaboration often becomes the first step toward broader regionalization. Agencies that work together on billing are more likely to collaborate on:

- Training and continuing education.
- Shared staffing pools.
- Joint purchasing of equipment.
- Standardized protocols.
- Regional QRS support.
- Mutual aid agreements.

Billing becomes the administrative backbone that supports operational integration.

While collaborative billing offers significant benefits, it also introduces risks that must be managed carefully.

Governance and Control Concerns

Agencies may fear losing autonomy or control over their revenue. Clear governance structures, transparent reporting, and well-defined financial policies are essential to maintaining trust.

A regional billing office must implement robust data security measures, including:

- Encrypted data transfer.
- Role based access controls.
- HIPAA-compliant storage.
- Regular audits and training.



Failure to manage data securely could expose all participating agencies to liability.

Transitioning to a collaborative billing model requires:

- Migrating data.
- Standardizing documentation.
- Training personnel.
- Integrating software systems.

These transitions can be disruptive if not managed with a structured implementation plan.

Variability in Agency Performance

Agencies with poor documentation practices may drag down overall performance. A regional model must include:

- Documentation audits.
- Provider education.
- Corrective action plans.

Without these safeguards, collaborative billing may not achieve its full potential.

Out-of-County Patient Stipend Model

One innovative opportunity within a regional billing framework is the ability to invoice out-of-county patients a standardized stipend. This stipend, separate from traditional EMS billing, can help offset the cost of providing services to non-residents who do not contribute to local tax bases.

Purpose

The stipend can be used to support:

- QRS operations.
- Training and continuing education.
- Equipment replacement.
- Medical supplies.
- Capital projects.
- Recruitment and retention initiatives.

Because out-of-county patients often represent a disproportionate share of uncompensated care, a stipend helps ensure that local taxpayers are not subsidizing EMS services for non-residents.



Implementation Considerations

A stipend model requires:

- Legal review to ensure compliance with state law.
- Clear communication to patients and municipalities.
- Standardized fee schedules.
- Integration with billing workflows.
- Policies for hardship waivers or appeals.

The stipend must be applied consistently to avoid claims of inequity or improper billing.

Even a modest stipend, such as \$50 to \$100 per out-of-county patient, can generate meaningful revenue when applied across thousands of annual transports. These funds can be earmarked specifically for system improvements, reducing the burden on local municipalities.

Revenue Flow Comparison

Traditional Model:

Agency → Vendor → Payer → Agency (minus high fees)

Collaborative Model:

Agency → Regional Billing Hub → Payer → Agency (higher net revenue)

Strategic Recommendations

To maximize the benefits of enhanced and collaborative billing, counties and regions should consider the following steps:

1. Conduct a billing performance audit across all participating agencies.
2. Develop a shared governance model with clear financial policies.
3. Standardize documentation requirements and provide provider training.
4. Select a unified billing platform or integrate existing systems.
5. Establish a regional denial management team to reduce revenue leakage.
6. Negotiate collectively with payers to secure improved reimbursement.
7. Implement the out-of-county stipend with clear legal and administrative guidelines.
8. Use regional billing data to support EMS system planning and funding advocacy.

Enhanced EMS billing and collaborative billing models offer powerful tools for strengthening EMS financial sustainability across counties and regions. By pooling resources, standardizing processes, and negotiating as a unified entity, EMS agencies can reduce administrative costs,



increase net revenue, and improve cash flow. These improvements directly support operational readiness, staffing stability, and long-term system resilience. The addition of an out-of-county patient stipend further enhances financial equity and provides a dedicated funding stream for QRS, training, supplies, and capital needs.

As EMS systems face increasing pressures, from hospital closures to staffing shortages to rising call volumes, collaborative billing represents a practical, high-impact strategy that can be implemented relatively quickly and scaled over time. It is both a financial solution and a catalyst for broader regional cooperation, positioning counties, and multi-county regions to build stronger, more sustainable EMS systems for the future.

County Commissioners Association of Pennsylvania Study

In addition to the recommendations outlined throughout this report, it is important to recognize that MCM Consulting Group, Inc. previously completed a comprehensive EMS Study in 2023 commissioned by the County Commissioners Association of Pennsylvania (CCAP). That effort produced a series of practical, implementation-focused toolkits designed to support EMS agencies, municipal leaders, and regional stakeholders in addressing the systemic challenges facing emergency medical services across Pennsylvania. Many of the conditions identified in that statewide study, particularly those related to workforce shortages, financial instability, and rural service delivery constraints, remain consistent with the findings of this regional assessment. As such, the toolkits developed through the CCAP study continue to represent relevant, actionable resources that can complement and reinforce the recommendations contained within this report.

The CCAP toolkits provide structured guidance in several critical areas, including governance and organizational models, regionalization and shared services, financial sustainability strategies, workforce recruitment and retention, and operational best practices. These resources are designed not only to define challenges but to offer step-by-step approaches, templates, and policy considerations that can be adapted to local conditions. For the six-county region assessed in this study, these toolkits offer a valuable extension of the recommendations presented, particularly in supporting agencies that may lack administrative capacity or formal business expertise. When paired with the data-driven and region-specific findings of this report, the CCAP materials can help bridge the gap between strategic planning and practical implementation.

Importantly, the alignment between the CCAP study and this regional analysis reinforces the broader conclusion that EMS challenges are not isolated but systemic, requiring coordinated and sustained action at the local, regional, and state levels. The inclusion of these toolkits in the



appendices is intended to provide agencies and decision-makers with immediate access to proven resources that can accelerate progress. By leveraging both the tailored recommendations in this report and the established guidance contained within the CCAP toolkits, stakeholders are better positioned to implement meaningful changes that improve service delivery, strengthen financial stability, and support a sustainable EMS workforce.



Conclusion

The comprehensive assessment of emergency medical services (EMS) across Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties reveals a system under significant strain yet rife with opportunities for transformation.

EMS agencies in the region studied represent diverse service models: volunteer, hybrid, and paid operating with budgets ranging from modest to multi-million-dollar scales, yet some face persistent deficits. Salaries remain competitive regionally but lag state averages in some categories, while benefits packages align with Pennsylvania norms. Enhanced financial stability requires treating EMS as a business: implementing professional management training, collaborative or in-house billing, joint purchasing, robust grant strategies, and exploration of public-private partnerships. The Pennsylvania Rural Health Transformation Plan's Rapid Response Stabilization Program offers immediate capital and operational support, with applications prioritized for equipment, facilities, and system stabilization. Future funding rounds targeting community paramedicine and mobile integrated healthcare (MIH-CP) align perfectly with regional needs.

Volunteer incentives help sustain community-based models, but in-kind municipal support remains underutilized, and many agencies operate without dedicated business acumen. These financial realities underscore an urgent need for enhanced management practices, shared services, and diversified funding streams to ensure long-term sustainability.

The closure of Bradford Regional Medical Center has amplified these challenges, extending transport times, increasing out-of-service intervals, potentially straining neighboring facilities. Longer response and turnaround cycles exacerbate staffing burnout, elevate operational costs, and heighten clinical risks for time-sensitive conditions. Rural geography imposes lengthy baseline transport distances, and the resulting system saturation threatens coverage gaps. However, this disruption also presents a mechanism for innovation, including strengthened regional coordination, community paramedicine expansion, telemedicine integration, and data-driven deployment strategies. Proactive collaboration can convert these pressures into opportunities for a more resilient, integrated rural healthcare network.

Recruitment and retention emerge as the most critical workforce issues confronting the region. Declining volunteerism, aging populations, competing employment opportunities, and demanding schedules have reduced the available pool of potential staff. Training barriers, including costs, travel distances, and reported National Registry exam challenges, further constrain the pipeline. Retention suffers from burnout driven by extended transports, low



compensation relative to responsibility, limited career advancement, and lack of infrastructure in the region to draw potential staff and their families. Targeted solutions such as tuition assistance, apprenticeships, mentorship programs, flexible “family-first” scheduling, regional staffing pools, and public recognition campaigns offer promising pathways forward. Partnerships with Workforce Solutions for North Central Pennsylvania, educational institutions, and EMS council can build sustainable pipelines through dual-enrollment programs, earn-while-you-learn models, and career ladders extending into community paramedicine roles.

Training and certification improvements are foundational to workforce development. Coordinated regional efforts to enhance accessibility, affordability, and quality through virtual continuing education, scholarships, standardized instructor training, and firsthand skill development will be essential. Aligning curricula more closely with National Registry expectations while leveraging successful models like Northern Pennsylvania Regional College can improve pass rates and reduce attrition. Public CPR/AED programs and community engagement initiatives simultaneously boost preparedness and serve as recruitment tools, fostering a culture where EMS is viewed as a valued, viable career.

Hospital interface inefficiencies, directly undermine EMS availability. Delays in patient handoff, inconsistent pre-arrival communication, ED overcrowding, and administrative bottlenecks extend out-of-service periods and contribute to provider frustration. Collaborative solutions, including standardized handoff protocols, dedicated EMS triage areas, real-time capacity dashboards, performance metrics, and joint EMS-hospital committees can target shortened offload standards. Reducing unnecessary transports could further alleviate pressure on both EMS and emergency departments.

Strategic recommendations center on modernizing operations and governance. System Status Management, adapted thoughtfully for rural contexts, dynamic deployment, station orders, and hybrid coverage models can optimize limited resources without excessive fatigue.

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) represent a transformative opportunity to shift from reactive transport to proactive, community-based care. Managing chronic conditions, reducing readmissions, and integrating telehealth, these programs preserve ambulance availability for true emergencies, improve patient outcomes, and generate new revenue pathways. Workforce Solutions can play a pivotal role in training, partnership facilitation, and funding alignment. Complementary nurse triage and LowCode pathways in PSAPs offer additional efficiency by diverting low-acuity calls, provided they maintain rigorous clinical oversight and quality assurance.



Collaborative billing stands out as one of the highest-impact, most achievable near-term strategies. Pooling resources across agencies or counties enable economies of scale, stronger payer negotiations, standardized documentation, faster cash flow, and data-driven planning. An out-of-county patient stipend model could equitably support QRS services, training, and capital needs. When combined with municipal tax support and expanded grant programs, these approaches create diversified, sustainable funding models tailored to local demographics and needs.

Ultimately, no single solution fits all communities in this diverse six-county region. Success depends on collaborative leadership among EMS agencies, municipalities, counties, state legislators, Workforce Solutions, hospitals, and educational partners. By investing in business acumen, workforce housing initiatives, regional training consortia, technology-enabled coordination, and innovative care models, the north central Pennsylvania EMS system can evolve from survival mode to a model of rural healthcare excellence. The challenges: financial fragility, hospital access loss, and workforce shortages are substantial, but the collective expertise, dedication, and community commitment present in the region provide a strong foundation for meaningful, lasting improvement. Strategic implementation of the recommendations outlined throughout this report will enhance sustainability, strengthen emergency response capabilities, and ensure reliable, high-quality prehospital care for residents across the region for years to come. Coordinated action today will build the resilient EMS system that rural Pennsylvania deserves.



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Appendix A – MCM Interview Form



EMS Interview Packet

Recruitment & Retention

- Describe your current staffing model (FT/PT/volunteer mix).
- What are your biggest challenges in recruiting EMTs and paramedics?
- What factors most affect retention in your agency?
- How many open positions do you currently have, and how long have they been vacant?
- What strategies have you tried to improve recruitment and retention, and how effective have they been?
- How does compensation compare to neighboring agencies or hospitals?
- What non-financial incentives (culture, scheduling, advancement) help keep staff?

Training & Certification

- How do you support EMT and paramedic certification and continuing education?
- What barriers do candidates face in completing EMT or paramedic training?
- How do National Registry testing requirements impact your agency?
- Do you have internal instructors or rely on external training centers?
- What training gaps do you see among new EMTs or paramedics?
- What additional training resources or partnerships would strengthen your agency?

Operational Rhythm & Service Delivery

- Describe your current call volume and trends over the past 3–5 years.
- What is your typical unit hour utilization, and how does it affect operations?
- How do you schedule crews, and what challenges do you face with coverage?
- What is your average response time, and what factors most influence it?
- What specialty services do you provide (QRS, rescue, community paramedicine, etc.)?
- What operational constraints most limit your ability to meet demand?
- How many on your current roster account for 10% of total call-for-service or 750 hours of scheduled shift time?
- What percentage of your total annual call volume is spent providing interfacility transports?
- Do interfacility transports remove units from their primary coverage?
- What is the time spent on interfacility transports from dispatch to back in service?
- How is coverage provided when an interfacility transport occurs?



- Does your service experience hospital off-loading delays? How long is the average delay?
- Have off-load delays caused your unit(s) to be out of service and in-turn affected a second call in your area?
- What are your minimum staffing requirements to keep one BLS/ALS unit in service?
- How often is a unit dropped from your availability due to staffing shortages?
- What is the average age of your EMS responders?

Finance & Administration

- What are your primary revenue sources (billing, municipal contributions, grants, fundraising)?
- What percentage of billed revenue is actually collected?
- How do Medicare/Medicaid reimbursement rates affect your financial stability?
- What is your annual operating budget, and is it sufficient to meet current needs?
- What major capital needs (vehicles, equipment, facilities) are unfunded?
- What administrative burdens most impact your ability to operate effectively?
- What percentage of income is spent on salaries and benefits?
- What is the pay scale or hourly rate for employees?
 - Administration
 - Paramedic
 - EMT-A
 - EMT
 - Driver
- Are there any benefit packages provided to employees, including paid time off?
- Are there any incentives provided beyond the percentage of the budget?
- What is the average cost per unit hour?
- What is the average cost per transport?
- What is the average amount collected per transport?
- What is your payer mix (Medicare, Medicaid, commercial, self)
- Has your agency operated at a financial deficit at any time in the last three years? If so, how was the deficit covered? (Reserves, municipal, loan, other)
- What is the average wage for EMT (starting vs. five plus years' experience)
- What is the average wage for a Paramedic (starting vs. five plus years' experience)
- Have you lost staff to hospital or other health care employments?
- How many staff has left EMS entirely in the past three years? Reason?



Regional Collaboration & System Coordination

- How do you coordinate with neighboring EMS agencies?
- What mutual aid agreements are in place, and how often are they activated?
- How effective is communication with county 911 centers?
- What regional challenges could be solved through shared services or joint planning?
- What governance or regional framework would best support your agency?

Strategic Needs & Future Planning

- What are the top three changes that would most improve EMS in your county or region?
- What innovations or models (e.g., tiered response, regional staffing pools) interest you?
- What support do you need from counties, municipalities, or the Commonwealth?

Open-Ended Input

- What issues have we not asked about that you believe are critical to EMS sustainability?
- What else should the region understand about your agency's challenges or strengths?

QRS Interview Packet

Recruitment & Retention

- Describe your current QRS staffing model (career, volunteer, mixed).
- How many personnel are certified to provide medical response?
- What challenges do you face in recruiting new QRS responders?
- What factors most affect retention of medically trained fire personnel?
- How do competing demands (fire, rescue, EMS) impact staffing availability?
- What incentives, financial or non-financial, help keep responders engaged?
- How has your staffing level changed over the past 3–5 years?

Training & Certification

- What medical certifications do your QRS responders hold (EMT, EMR, paramedic)?
- How do you support initial certification and continuing education?
- What barriers do members face in completing required medical training?
- Do you have in-house instructors or rely on external training centers?
- How do you maintain competency in medical skills given call volume and staffing?
- What additional training resources would strengthen your QRS program?



Operational Rhythm & Service Delivery

- Describe your QRS call volume and trends over the past 3–5 years.
- What types of medical calls does your QRS unit typically respond to?
- What is your average turnout time for QRS responses?
- How often does your QRS unit arrive before the transporting EMS agency?
- How do you coordinate on-scene roles with EMS providers?
- What equipment do you carry on QRS apparatus, and what gaps exist?
- What operational challenges most limit your ability to provide timely QRS response?
- How do fire suppression or rescue incidents affect QRS availability?

Finance & Administration

- What is the annual cost of operating your QRS program?
- What funding sources support QRS operations (municipal, fundraising, grants, fire tax)?
- Do you receive any financial support specifically for medical response?
- What in-kind support do you receive (fuel, facilities, utilities, insurance)?
- What major equipment or capital needs are unfunded (AEDs, bags, vehicles)?
- How do administrative requirements (reporting, QA/QI, training records) impact your agency?
- What financial challenges most threaten the sustainability of your QRS program?

Regional Collaboration & System Coordination

- Which EMS agencies do you most frequently interact with on medical calls?
- How effective is communication between your QRS unit and EMS providers?
- Do you participate in county or regional EMS/fire coordination meetings?
- How well does the 911 center support QRS dispatching and situational awareness?
- What mutual aid or automatic aid agreements affect QRS response?
- What regional challenges could be addressed through shared services or joint planning?
- What governance or regional framework would best support QRS operations?

Strategic Needs & Future Planning

- What are the top three improvements that would strengthen QRS service in your area?
- What innovations or operational models (e.g., integrated EMS–fire response) interest you?
- What support do you need from municipalities, counties, or the Commonwealth?



- How do you see the role of QRS evolving over the next 5–10 years?

Open-Ended Input

- What issues have we not asked about that you believe are critical to QRS sustainability?
- What else should the region understand about your department's medical response role?
- Is there anything additional you want to share about QRS operations in your community?



Municipal / Elected Leader Interview Packet

(Awareness of EMS obligations, financial support, legislation, agency relationships, and local expectations)

Awareness of EMS Responsibilities & Legislation

- How would you describe your municipality's role in ensuring EMS coverage?
- Are you aware of Pennsylvania legislation related to municipal EMS responsibilities?
- Are you familiar with Act 7, Act 17, or other EMS-related statutes?
- Do you believe your municipality is meeting its statutory obligations for EMS?
- How do you stay informed about EMS issues affecting your community?

Understanding of Local EMS Operations

- Which EMS agency or agencies provide service to your municipality?
- How would you describe your working relationship with those agencies?
- How often do you communicate with EMS leadership?
- Are you aware of their staffing levels, response times, or operational challenges?
- Do you receive regular reports or updates from EMS providers?

Financial Support & Funding Mechanisms

- Does your municipality provide direct financial support to EMS?
- If yes, what is the annual dollar amount?
- What form does support take (appropriation, contract, subscription purchase, donation)?
- Do you provide in-kind support (fuel, facilities, insurance, utilities, equipment)?
- If yes, what is the estimated annual value of those contributions?
- Do you levy any taxes or fees specifically to support EMS?
- Have you considered implementing EMS cost-recovery ordinances or subscription programs?
- What financial challenges limit your ability to support EMS?

Expectations & Service Delivery

- What are your expectations for EMS response times in your municipality?
- How satisfied are you with current EMS performance?
- What concerns have residents expressed about EMS service?
- What improvements would you like to see in EMS operations or communication?



Regional Collaboration & Planning

- Are you aware of regional EMS challenges affecting your municipality?
- Would you support a regional EMS authority, shared services model, or joint funding approach?
- What barriers do you see to regional collaboration?

Open-Ended Input

- What additional information would help you better understand EMS needs in your community?
- What issues or concerns have we not asked about that you believe are important?
- Is there anything else you want to share about EMS in your municipality?



EMS Educational Provider / Training Facility Interview Questions

Program Overview & Capacity

1. Please describe your EMS education programs (EMT, AEMT, Paramedic, continuing education), including delivery format (in-person, hybrid, online).
2. What geographic area does your program primarily serve, and how far do students typically travel to attend?
3. What is your current annual enrollment capacity for each program, and what percentage of that capacity is typically filled?
4. What factors most limit your ability to expand enrollment (faculty availability, clinical sites, funding, facilities, scheduling)?

Student Demographics & Pipeline

5. What is the general demographic profile of your students (age ranges, career changers vs. new entrants, volunteer vs. paid EMS)?
6. Approximately what percentage of your students are above age 30, and how do their outcomes compare to younger students?
7. How many graduates typically enter paid EMS employment versus volunteer or combination agencies, if known?
8. What percentage of students leave the program before completion, and what are the most common reasons?

Certification, Testing & Outcomes

9. What are your recent completion and certification pass rates (state and/or National Registry) for each program?
10. What barriers do students face in passing certification exams (academic readiness, test anxiety, cost, time off work)?
11. Are there differences in outcomes between state certification and National Registry pathways, and how do those differences affect workforce readiness?
12. What supports (tutoring, remediation, exam prep, mentoring) have proven most effective in improving pass rates?

Instructor Workforce & Educational Quality

13. How many instructors do you currently rely on, and are they primarily career EMS, volunteers, or part-time educators?



14. What challenges do you face in recruiting, retaining, and credentialing qualified EMS instructors?
15. How do instructors stay current with annual changes in state protocols, National Registry standards, and curriculum updates?
16. Are instructor shortages limiting course availability or frequency?

Accessibility, Affordability & Equity

17. What is the approximate out-of-pocket cost for students by program, and what financial barriers most affect enrollment or completion?
18. What funding supports exist today (grants, scholarships, sponsorships, employer, or municipal support)?
19. How accessible are your programs for rural students in terms of scheduling, transportation, and clinical placement locations?

Partnerships & Strategies

20. What partnerships do you currently maintain with EMS agencies, hospitals, high schools, post-secondary institutions, or workforce boards?
21. Have you participated in or considered apprenticeship, earn-while-you-learn, or tuition-reimbursement models with EMS agencies?
22. What role could Workforce Solutions or counties play in strengthening recruitment pipelines into your programs?

Regional Alignment & System Improvement

23. Where do you see misalignment between EMS education, certification requirements, and the operational realities of rural EMS agencies?
24. What opportunities exist for greater regional consistency in curriculum delivery, protocol instruction, or testing preparation?
25. If you could recommend changes that would most improve EMS education outcomes and workforce readiness in this region, what would they be?



EMS Council Staff Interview Questions

System Oversight & Regional Perspective

1. From the EMS Council's perspective, what are the most significant workforce challenges currently affecting EMS agencies in the region?
2. How do workforce challenges differ between counties, rural vs. more populated areas, or volunteer vs. paid agencies?
3. Where do you see the greatest risk to service continuity if current trends continue?

Workforce Recruitment, Retention & Demographics

4. What trends are you seeing related to aging responders, declining volunteerism, and workforce attrition?
5. Are there particular agency types or service models that appear more resilient? Why?
6. How frequently do agencies report staffing-related service interruptions, coverage gaps, or unit downtime?
7. What role, if any, does the EMS Council play in supporting recruitment or retention initiatives today?

Training, Certification & Education Alignment

8. What recurring issues do agencies or students raise regarding EMT or paramedic training accessibility and availability?
9. From your perspective, where are the biggest disconnects between education programs, certification requirements, and operational readiness?
10. How do National Registry testing requirements impact staffing and workforce stability across the region?
11. Are instructor shortages, course frequency, or clinical placement capacity limiting workforce development?
12. How effective are current processes in keeping instructors and agencies aligned with annual protocol or curriculum changes?

Operations, Coverage & System Flow

13. How do staffing shortages affect response times, mutual aid reliance, and after-hours coverage at a system level?
14. What impact do interfacility transports, low-acuity calls, and hospital offload delays have on workforce fatigue and availability?



15. Are current ambulance licensing rules or legacy requirements contributing to inefficiencies or staffing strain?

Municipal Roles, Funding & Legal Context

16. Based on your interactions, how well do municipalities understand their legal responsibilities for EMS service provision?
17. Where do you see the most confusion or inconsistency in funding approaches or expectations?
18. How does transitioning from volunteer to combination or paid models affect agencies in terms of compliance, liability, or sustainability?

Regional Coordination & Improvement Opportunities

19. What opportunities exist for stronger regional coordination, such as shared staffing models, standardized training pipelines, or governance structures, while preserving local identity?
20. If you could recommend system-level changes to improve workforce sustainability and service reliability across the region, what would they be?



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Appendix B – Survey Invitation Letter



March 4, 2026

Hello,

Workforce Solutions has contracted MCM Consulting Group, Inc. (MCM) to conduct an EMS needs assessment and strategic plan for Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties. As part of the needs assessment, a user survey has been created, and your response and input would be appreciated.

Here is a link to the survey: <https://www.surveymonkey.com/r/WS-EMS>

Or use the QR code below to launch the survey.



Please complete the survey by: March 19, 2026.

MCM will be reaching out to your agency between March 9, 2026, and March 20, 2026, to schedule in-person interviews to review your completed survey and gather additional information.

Contact Jeffery Steiert, MCM Consulting Group, Inc., JSteiert@MCMConsultinggrp.com, phone 484-546-9023, with any questions.

Thank you for participating.

Best Regards,

Jeffery Steiert, PMP
Project Manager
MCM Consulting Group, Inc.



March 4, 2026

Hello,

Workforce Solutions has contracted MCM Consulting Group, Inc. (MCM) to conduct an EMS needs assessment and strategic plan for Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties. As part of the needs assessment, a user survey has been created, and your response and input would be appreciated.

Here is a link to the survey: <https://www.surveymonkey.com/r/WS-Municipal>

Or use the QR code below to launch the survey.



Please complete the survey by: March 19, 2026.

MCM will be reaching out to you between March 9, 2026, and March 20, 2026, to schedule in-person interviews to review your completed survey and gather additional information.

Contact Jeffery Steiert, MCM Consulting Group, Inc., JSteiert@MCMConsultinggrp.com, phone 484-546-9023, with any questions.

Thank you for participating.

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Empowering a Safer World[™]



328 Innovation Blvd, Suite 222
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Appendix C – Combined Interview Responses



EMS Interview Packet

Recruitment & Retention

- Describe your current staffing model (FT/PT/volunteer mix).
 - 8 FT, 22 PT
 - Volunteer – a lot of camps, not full-time residents
 - All – FT/PT/Stipend, casual volunteer
 - All volunteers
 - Mostly all part-time staff – do not offer any benefits to any of the staff.
 - Hybrid. FT/PT staff, vol and paid on-call staffing.
 - 42 total – 15 full time including managers, two crews 24/7 – ALS 99% two full ALS crews if don't have two they supplement with IALS or BLS, daytime have 3 – 5 ambulances and one interceptor 4 are ALS
 - Primarily full-time staff are paramedics; part-time staff are EMT and Advanced EMTs. The staffing model has been like this for approximately 30 years. Part-time staff. The majority are 32-40 hours per week. Shifts are 8, 10, and 16-hour shifts.
 - 100% are volunteers and 5 routinely run calls. May be 2 additional run calls infrequently.
 - Full time and part time, no volunteers
 - All volunteers
- What are your biggest challenges in recruiting EMTs and paramedics?
 - Wages, which used to be lowest, are now comparable to other agencies
 - No one to recruit, “who you are” clicks
 - No one is available. No one wants to volunteer. The pay for EMS careers is not sufficient to provide pay for calls. Most use the career in EMS as a steppingstone to another career somewhere. Mostly, they are available for 2-4 years.
 - Trying to find people for recruitment. The area is essentially made up of Amish and elderly individuals; there are not a lot of younger individuals willing to



volunteer. Retention ... started paying for classes.... had to run so many calls and cover events or pay the amount back.

- There are not enough available individuals, and those that are trying cannot pass the test. One has taken the test twice and failed both times. The NR test is difficult, high rate of failure.
- Funding / ability to pay. Limited/no available pool of candidates and funding to support recruitment/enticement of staffing.
- Available workforce, financial ability, wages
- Need the ability to pay them and train them. Run their own EMT class – one month off between classes. Medical director and other med command docs will participate in teaching. People do not want to take the National Registry portion. Part of registration for the class includes the cost to take the NR test. Younger people are more comfortable with the National Registry test as this is based entirely online. Region held a “how to navigate” the test, test-taking strategies, which helped with the pass rate. Has not looked at pass rates against other ETFs.
- [We] staff by creating employees through [the] EMT Academy. There are no significant recruiting challenges.
- If industry is in the area, jobs would be created and bring people to the area. No “new” residents moving into the area.
- Cost of the classes and time of the class. NPRC teaches all about the book; it teaches nothing about ambulances or tools on the truck.
- Lack of a recruitment base – simply, there are not a lot of people. People do not want to spend the time travelling (1-2 hours) to a class and attend the EMT course.
- Small town – younger individuals are gone out of high school looking for work.
- What factors most affect retention in your agency?
 - Retention is pretty good. Full-time got additional pay if they opted out of insurance, had to provide other coverage
 - Not a lot of calls, work schedules



- Paramedic requirements in PA are very taxing. Penn State Dubois and Lockhaven Clearfield are closing in the next few years – quite a few new EMTs came out of these programs.
- No
- Unsure if it is a retention problem – more of a recruitment issue. The agency struggles to maintain adequate staffing 24/7. No one is available to fill the vacancies.
- Does not have a lot of staff turnover Some have left for other opportunities in EMS.
- Burnout, long shifts – one call can take three hours
- Did a great job teaching how to call 911, but not WHY to call 911. Repeat “regulars” who do not need an EMS unit.
- Wages
- Free time / availability.
- Dedication... younger staff/group are not dedicated to working.
- There is an aging volunteer base with no one to fill those potential vacancies.
- A lot of the staff have been here for many years. Many restrictions, requirements, and changes affect people’s interest.
- How many open positions do you currently have, and how long have they been vacant?
 - No full time – would hire more part time, but don’t need it urgently
 - 2.5 FT Paramedic positions; 2 FT EMT positions. Open positions since 2020 – revolving basis.
 - There are no current vacancies – have some people who work nearly 100 hours per week.
 - 1 FT Paramedic – open for ~4 months.
 - No full time – will hire part time but not an urgent need 60% staffed by full time
 - 5-10 open positions that are ongoing. With EMT classes, we have been able to fill quite a bit of the open positions.



- Would like to double the number of responders but being an all-volunteer agency there are not “open” spots.
 - 4-6 that have been open for three years. No one fills the positions that are certified.
 - Always open.
- What strategies have you tried to improve recruitment and retention, and how effective have they been?
 - Part-time people can respond from home if they live within 5 minutes. Have to do truck checks, etc. at the beginning of shift. Treatment of staff, provide lunch, and staff appreciation items.
 - Started to recruit as captain, has not continued with new captain – Some part-time camp owners are willing to volunteer
 - Attempting to engage more through social media. Send Deputy Director to social media training. (NAAC Lawyers) putting on an EMS engagement class in Florida. Using Facebook and Instagram. Working with the school district. Able to increase wages last year prior to Penn Highlands.
 - The agency advertises and sends fund requests out with literature included requesting volunteers. Request volunteers on Facebook and other social media.
 - Most advertising is “word-of-mouth” – just picked up one individual who is working part time. “Do you know anyone....”
 - Attempted to cover different kinds of recruitment, but no candidate pool
 - No specific strategies, improved overall environment and morale, poor toxic environment, bonuses, employee gifts, full fringe benefits
 - In-house EMT program. Work well with police and SRO program – future first responders club – mock crashes, etc., very well attended. Promotes the EMT class and funnels some students to EMS. EMT classes are word of mouth – students can attend and stay or move to another agency.
 - EMT Academy, salary/wages, benefits, employee engagement team, work life balance



- Agency secured training for the fire department as first responders. FF did not want to recertify and did not have time for continuing education, and the membership decreased. EMS agency paid for EMT class for two, but those individuals dropped out or moved away.
 - Unknown
 - Retention: No. People either want to be involved or they do not.
 - Have not done enough to keep people – unsure how to keep volunteers. *Does not have a jr. program anymore because they aren't interested. Suggested a retirement/pension program offered by the Commonwealth as an incentive.
- How does compensation compare to neighboring agencies or hospitals?
 - Used to be lowest, now comparable to other agencies
 - Pay is not competitive with healthcare networks.
 - [We are] way below other agencies when it comes to pay. (EMSVO making \$10/hour)
 - [We are] comparable to similar sized /adjacent entities.
 - Equal and higher
 - [We are] “near the top” – two years ago, substantially increased their wage scales, full-time health care (pay zero for health care, including reimbursement for any co-pays).
 - Good to higher
 - \$100 gift card after ten EMS runs are provided. All other services surrounding one agency] are paid services.
 - [We are] trying to stay competitive. TLC tries to stay several dollars ahead of the surrounding agencies.
- What non-financial incentives (culture, scheduling, advancement) help keep staff?



- See two above for information – used to be 16 hours of sick time per year after 90 days, and each anniversary date get 40 hours of sick time – transferred into a sick bank maxed out at six weeks
- Used to pay for class, now you have to sign an agreement or pay for it yourself, may not be reimbursing anymore, used to be a program in [our] County to pay for it.
- Family first scheduling – based on employee schedule; some split schedules that keep the schedule complete. Provide uniforms except for pants and boots. Service provides lunch once a week with the staff and includes the fire side of the service. Assist with daycare/childcare when staff have family commitments, etc., until other arrangements can be made.
- None
- No advancements. The agency will provide tumblers for EMS week. Relaxed culture.
- “Open” scheduling – ability to plan long-term.
- Culture
- Very “big” on advancement, ties to a benefit – staff that want to take A-EMT, board fronts the money and pay it back through a pay deduction. Investment in our people, and training is in-house. EMS week includes dinners, get together, and holiday parties. Staff hosts dinner gatherings tied into an hour of con-ed.
- Most staff are from outside the area, so they are permitted to work 24 hours. There is an employee engagement team to promote culture, celebrate holidays, etc. Training through the EMT Academy.
- No
- NA. We would be willing to provide stipends, but that does not bring people in the door.
- School district started a tax relief program last year. No other non-financial incentives.



Training & Certification

- How do you support EMT and paramedic certification and continuing education?
 - [Removed], has a training institute he provides training, Service manager is a BLS instructor. One person in-person con-ed per month, VFIS for annual training - Have reapplied for IALS credentials
 - Some continuing education
 - The EMT Academy
 - 75% of paid and volunteer staff are nationally certified....this number includes the fire side. Try to provide one in-house con-ed.
 - Pay for their classes, and the individual is responsible for participating in calls/events for a period of two years; 20-30 calls withing that two-year period.
 - Certification and con-ed are up to the individual. The agency will pay for a combined class once in a while; do not reimburse EMT for con-ed.
 - Multiple instructors to perform in-house. Cover \$ of con-ed if they attend outside of the agency. New Medic training costs are covered by the agency. Not currently covering EMT (well-staffed ATM), but would, as needed.
 - Multiple instructors on roster, all free of charge, work with regional EMS council
 - House EMT program, con-ed dinners. Medical command through Allegheny, docs come in and support staff – trying to get staff into Allegheny General for the level 1 trauma center and training.
 - EMS agency supplies/hosts con-ed classes, which have been offered as extended to other agencies surrounding.
 - Try to host classes; several EMT instructors on staff to conduct in-house con-ed.
 - Try to schedule classes for CPR ... individuals are responsible for obtaining their own CEUs. The agency reminds staff when there are opportunities available – including working with EMS West – for basic yearly certification. The agency only has one active EMT. Can also take online courses.
 - [We are]a con-ed sponsor, try to get classes, and coordinate with other agencies. Recently, paid for several of the volunteers – 2 of 4 failed the NR test.



- What barriers do candidates face in completing EMT or paramedic training?
 - None – a lot of training is provided. [Removed] obtained a grant and will be offering EMT classes for free to residents of [our] County. IALS will be able to take that for free
 - Training. Length of training for EMS, time needed off work. Need drivers to only have to be trained to drive and not further trained.
 - Cannot train Paramedics at their training facility. Paramedic classes are \$6500 per student at IUP. Candidates struggle with working full-time and attending classes and practical sessions. If the state would allow [us] to run a paramedic class
 - Students themselves. There is a dedicated training team to educate and assist trainees. Trainees are employees so there is investment on both sides to engage and succeed in training. There has been a 100% national registry pass rate for the past several classes.
 - Most are upset with the National Registry; all learning/testing is required to be completed online. Some candidates are slow readers and cannot complete the sessions in the time allotted.... The program kicks them out or onto the next session.
 - NR comments above. No barriers to continuing education. NR test is the barrier for initial EMT candidates.
 - Difficulty locating the training locally. Some local services are trying to run EMT classes.
 - Not continuing education, some don't want to advance certification, higher certified not untrained, working on becoming a satellite facility for North Central regional college
 - Getting them to the testing point. JBL learning program on-line. Generational "thing" – older struggle with the e-learning style, whereas the younger generation is more used to the e-learning. Financial barriers exist, as well.
 - Training used to be locally held, but those classes have since moved to higher educational entities for training. Also, class requirements for minimum attendees are required.
 - Funding and time needed.



- Distance to the training location/s. As an ambulance association, it will pay for the training, it is a matter of the candidate making time to attend.
 - National Registry requirement – cost of testing.
- How do National Registry testing requirements impact your agency?
 - They do not impact
 - Limited on National Registry, an additional burden to volunteers. Don't think they need it.
 - Continuing education credits are at a cost.
 - As above
 - No one in the agency is NR certified and we do not intend to obtain it.
 - Difficult process [for most/all]. Testing requirements. PC requirements / similar to other agencies, some groups struggle with completing the process online (v. paper)
 - Minimal
 - Students are trained to National Registry and pass the exam.
 - EMS agency offers con-ed (EMS instructor) to keep the registry certification.
 - Everyone is afraid to take a test on the computer. Some candidates have difficulty taking written exams.
 - Current classes do not instruct anything related to the ambulance. There are not enough clinical hours to instruct properly.
 - Unsure. It may be intimidating and harder, unable to pass the test because it may be more difficult. Must go to another location to take the test, and there are no locations inside 90 minutes' drive from the municipality.
 - Cannot afford the test, fail it, and are afraid to fail again, or simply do not want to take the test. Testing portions time out and move on without allowing them to go back.
- Do you have internal instructors or rely on external training centers?
 - Internal, use some external



- Internal instructors provide continuing education sessions monthly. Curwensville is their own training center as of 2020 for BLS to train EMR and EMT. Can provide private and public classes.
- We have one instructor that assists with CPR training. Other ETF or agency instructors provide con-ed.
- External only.
- Multiple instructors to perform in-house.
- Mostly internal, use external for certification, and regional council
- In-house EMT program.
- Internal instructors. There is an education team. It appears that agencies with internal training teams have a higher national registry success rate.
- Rely on all external training centers.
- In-house instructors and also rely on external instructors for things like EVOC, etc.
- External.
- Instructors are through different departments that conduct con-ed and other training.
- What training gaps do you see among new EMTs or paramedics?
 - No
 - Not enough people to run the class, travel, or do group training
 - Need to teach 12-lead EKG but candidates are not able to perform a 12-lead until they take the continuing education.
 - Not a whole lot in this area.
 - Unsure. Afraid for the new generation due to operating on electronics and having no social skills.
 - Training facilities handle this very well, with no real identified gaps.
 - No



- None. There are mandatory training days scheduled for staff twice a year. Any areas of deficiency are quickly noted and added to the curriculum
- Hybrid model offers limited experience – once in the field, new staff are trepidatious to perform a patient assessment. Lessons are completed online, and one or two days of practical “here and there” and not practicing as much as they should. Exposure to the ER and patient assessments could be included as part of the educational process.
- Didactic, but not enough real-world experience for new EMS providers.
- There are a lot of abbreviations. Online training, no hands-on training. Students are not taught properly. **Prefer “old-school” in class, in-person ways of instruction.
- What additional training resources or partnerships would strengthen your agency?
 - Documentation training
 - Better access to training would help.
 - NIMS 100, 700, 800...no money for DHS. DOH granted a waiver, but there is no ability to eventually take the classes. Penn Highland Healthcare now wants a 10-drug screening on students prior to performing rotations through the facility.
 - We are at a good point with training classes. Con-ed sessions offered are announced / listed on Facebook. EMS West publishes a listing of classes a month to three months ahead of the session.
 - Unknown
 - No
 - None
 - Having additional instructors in the region would be helpful. There is a lack of available space in classes and a lack of classes available.
 - Tied in with the hospitals, but the way they view us is as transportation. Handle a lot of IHOP to Philadelphia and Pittsburgh; patients are being monitored, cared for, and transported. Provider-hospital relationships need to evolve. EMS has become the dumping ground for patients with mental health issues; they do not



receive the proper care – where this should be treated without stigmas and treated as a disease like any other.

- If we could share personnel from other agencies, it would be helpful. Other agency's quick response type personnel would be beneficial.
- Unsure. Currently, partner with regional entities/agencies to conduct training. Clinton County was trying to form a training center, but it is 55 miles away. Kids may take the courses in HS or college, but they leave the area; very few remain.
- Training – more inter-departmental training, MCI, etc. Need a standard for partnering up with mutual aid providers – i.e. – some do not practice incident command.

Operational Rhythm & Service Delivery

- Describe your current call volume and trends over the past 3–5 years.
 - 2024 to 2025 increased 94 calls, started doing transports which increased call volume. IALS will increase call volume. 2026 is in line to be ahead of 2025 currently at 225 calls.
 - About 35 for the year, over the last 3 to 5 years
 - Every year over the last 14 years have been busier than the last except 2020. Emergency calls have effectively remained the same. Call volumes average 2600/year. Future calls are being taken away through Jet EMS with transports.
 - Annual call volume averages 300 calls/year including refusals, fire scene standbys, transports.
 - 500 calls per year / 400 are transported. Call volume may have increased slightly. Handle a lot of lift assist. (They are billing for lift assists).
 - Call volume continues to increase annually (~10-15 calls). 1225 call/year.
 - Steady – 3200 to 3500 calls per year, including transports
 - Call volumes have dropped.... Due to lack of staffing. Amount of calls are changing – a lot of geriatric patients; 3 skilled facilities and one assisted living facility. After Covid, call volume dropped from 8k to 5-6k request for service.



- Stable at approximately 1,100 calls per year including emergency and non-emergency
 - 150 calls in 2025. Call volume fluctuations occur but remain relatively stable.
 - Call volume is approximately 500 calls per year. 1.5 calls per day. Call volume stays fairly consistent.
 - Average transported calls – 35 to 45 /year. Last year they hit a high of around 50 while the current year is slower.
 - Call volume is approximately 280 calls/year. Call volume remains fairly static.
- What is your typical unit hour utilization, and how does it affect operations?
 - 1.5 to 2 hours due to distance from hospital
 - 2 to 3 hours, plus paperwork
 - Not tracked very well through EMS Charts.
 - Unknown
 - 11
 - Unavailable information – the agency did run stats but does not have a breakout other than 8a-10p typically being the busiest.
 - 10a-10p is the busiest time of the day. 2nd ALS calls can be difficult to staff.
 - Pull reports from EMS charts, breakdown of “by hour” with peak times between noon and 5:00 p.m., falls off until 11:00 p.m., Tuesdays and Fridays are the busiest days of the week. Extra staff are added as a result.
 - Depending on the location of the emergency, 20-25 minutes is typical 45-1:15 transport times. This keeps the EMS unit unavailable for subsequent calls.
 - Busiest times are in the evening hours, but they do not increase staffing or trucks for busy times.
- How do you schedule crews, and what challenges do you face with coverage?
 - Full time – rotation, 24 and 16 per week. Part time is scheduled to fill in open space.



- Yes
- One to two trucks per shift. Use of family scheduling. ALS crew (8-hour blocks) around the clock. Management onsite daylight hours. Family scheduling does not always allow crew alignment to match a complete truck.
- There are no set schedules – crews are formed once the call is dispatched and if people are available. We used to schedule crews, but people stopped informing us when they were available.
- Crews are scheduled whenever they can work. Crews are permitted to go home overnight.
- Open scheduling as discussed above. 1 crew 24/7 – paramedics work 24-hour shifts, EMT work 24 hours on, as well.
- Monthly schedule, primarily fill time, open slots filled at responder request
- Taking advantage of staffing exception – use ALS, BLS, and Intermediate crews. It is our position to staff as able to treat patients to the highest level of available staff.
- One ALS truck is staffed 24/7. A truck will be moved to maintain coverage for transports so that the area is not left without a staffed vehicle.
- No schedule exists – station is toned out and those available respond.
- Crews are scheduled 24/7. Issues surround very limited staffing and their availability.
- Only one EMT – when home, I answer calls, and when I’m away, the next crew is notified the service is out of service.
- No schedule – toned out and whoever shows up, takes the call.
- What is your average response time, and what factors most influence it?
 - 2-5 enroute, on scene – 2 to 10 or 15 minutes depending on location
 - Below 15 minutes, depends on who is around.
 - 2-3 minutes out the door, now “killed” with technology. Turning into a safety factor – screen the call with the dispatch information on the phone or device.



Crews are taking a bit of extra time reviewing the EMD questions, and determine what resource is ultimately assigned to the call.

- Dispatch to on-scene averages 10-15 minutes. Many staff do not live near the station.
- Average response time is just under ten minutes. Since paying a daytime crew, response times are around 5-6 minutes; evenings remain around the ten-minute mark.
- 2–4-minute response daytime. At night, 6-8 minutes.
- 7.5 minutes
- 10-20 minutes with longer response times in the Cooks Forest area and camping areas. Winter conditions affect that response times, as well. Other EMS stations out of service and coverage range to near Altoona and Sheffield.
- Within a couple minutes to enroute. On scene can be anywhere from a couple minutes to half an hour or more depending on location.
- Roughly 10 minutes...lack of personnel and their availability.
- 5-8 minutes; early morning hours may extend that time.
- Distance to the location influences – 10 miles from the station – we cover almost 300 square miles. Response times could be as little as seven minutes or upward of 20-25 minutes. Some response times could be as high as 40 minutes if they respond to camping areas, or areas not accessible to the vehicle.
- Out the door within 5 minutes.
- What specialty services do you provide (QRS, rescue, community paramedicine, etc.)?
 - When [we] become IALS – advanced EMTs – will add several paramedic skills
 - None
 - Fire department performs the rescue services. EMS agency has two trucks licensed as QRS services but will only respond after the ambulance is out on another call or if it is out of service.
 - None



- None
- Standby services for events in community, outreach education, community education programs
- None of these. Wheelchair van transportation. Will use medical command to determine if a patient does not need a transport truck; limitation is that they only have one wheelchair van driver.
- Used to provide community paramedicine, would like to again.
- No
- What operational constraints most limit your ability to meet demand?
 - Financial reimbursements
 - Lack of people, lack of funding.
 - A lack of volunteers available, especially during the daytime, limits the ability to handle calls.
 - Being on other calls. Only two calls went uncrewed in 2025.
 - 1 ALS provider lives in town, others are outside/adjacent; 1 FT EMT lives in-town. Some FR live in town to over additional call volume.
 - Not many, equipment overuse possibly, ambulances out of service
 - People – lack of people. Need people to staff the trucks.
 - Finance. The station operates in a deficit.
 - Number of available personnel.
 - Lack of personnel to staff trucks.
 - Lack of volunteers.
 - Lack of personnel.
- How many on your current roster account for 10% of total call-for-service or 750 hours of scheduled shift time?
 - 100%



- About half handle most of the calls
- Out of the volunteer base, there are 4 who regularly run calls out of a total of nine people; 2 of them take evening calls routinely. There are five additional people who do not routinely run calls but will cover standbys and calls when asked.
- 6-7 individuals ... there are only ten volunteers overall.
- Two
- Some of the paid per call crew live nearby and typically are available to cover secondary calls.
- Filled by full-time staff
- Majority of those on the roster. Some are pulling 2600-2700 hours per year.
- 100%
- Unsure
- 3 out of the 12 EMTs.
- What percentage of your total annual call volume is spent providing interfacility transports?
 - 29 transports of 225 calls since January
 - None
 - 27% account for non-emergency transports. (40% during 2025 due to Penn Highlands)
 - Less than 10%
 - 40%
 - 15 – 20%
 - 50% or more of the activity is IHOP- this is time spent, not call volume.
 - 15%, primarily to Erie of Pittsburgh with can range from 6 to 8 hours round trip.
 - Do not do IHOP
 - 20%



- Only one EMT
- Do interfacility transports remove units from their primary coverage?
 - Yes
 - Transport crews are not the same as the emergency crews; a truck is always available for emergency calls.
 - Yes
 - Yes
 - Backfill
 - Sometimes, not normally.
- What is the time spent on interfacility transports from dispatch to back in service?
 - 3 to 3.5 hours
 - Unknown
 - Local IHOP are 1 to 1.5 hours. If it is a STAT transfer, possibly 8 hours roundtrip, and those are mostly nighttime transfers.
 - 2.5 hours to a nearby facility. 7-8 hours for Erie or PGH
 - Call an additional crew if possible 1 hour
 - ~5 hours round trip.
 - 6 to 8 hours
 - 2-8 hours.
- How is coverage provided when an interfacility transport occurs?
 - Part timers or non-working crew have the option to take the transport or cover town.
 - Transport crews are not the same as the emergency crews; a truck is always available for emergency calls.
 - Calls are dispatched to the neighboring service; we only have one ambulance.



- Transfers will take a unit out of service, but the primary response is never left without a coverage rig.
 - Call standbys – operate two stations. If one truck leaves for IHOP, the other truck moves to the middle of the are, or rely on other services, or 911 to find a replacement ambulance to cover the call.
 - Backfill
 - A second crew is scheduled during IHOPs
- Does your service experience hospital off-loading delays? How long is the average delay?
 - Rarely
 - No
 - Yes. PHH has a nursing shortage. Difficulty in getting a nurse to come to the room and take report.
 - No
 - The service has experienced some problems recently – multiple ambulances lined up to off-load patients in hospital. It only occurred once and took 20-30 minutes.
 - Not typical to experience a delay.
 - Not since the pandemic
 - Very few. Generally, only happens at the northern hospital – the longest delay was 20-30 minutes until a bed was available. The average is 5-15 minutes.
 - No
 - No (Olean, NY does triage and is a busier facility, but very rarely transport there)
 - Yes. 0-30 minutes, but up to 2.5 hours.
 - Only one time in the last few years because beds were full.
 - Yes. Depending on the hospital, one is 2-10 minutes, and the other could be 2 minutes to an hour. One hospital closed in the area which causes more patients to be seen.



- Have off-load delays caused your unit(s) to be out of service and in-turn affected a second call in your area?
 - Rarely
 - Yes – this creates a delay in patient care.
 - No
 - No
 - NA
 - No
 - Yes, not often but it does happen.
 - Yes
 - Yes. Difficulty getting a second crew to cover the call.
- What are your minimum staffing requirements to keep one BLS/ALS unit in service?
 - No
 - Two people
 - Functioning with an EMT and a certified driver.
 - 1 EMT/1 EMSVO
 - 1 ALS/BLS provider
 - Exception rule. Generally, one ALS crew at each station, with a BLS or Intermediate crew at each station.
 - One paramedic, one EMT. At times two paramedics if an EMT is not available
 - Driver and EMT
 - 1 EMT and 1 EMSVO or EMR
 - EMT/EMSVO w/FA and CPR.
- How often is a unit dropped from your availability due to staffing shortages?
 - No



- Quite a bit
 - Very infrequently
 - Depending on the month of the year, 1/3 of the calls are not crewed.
 - Rarely
 - Zero turnover for 1st calls. Handful of turnovers for 2nd/3rd calls <5/year
 - No
 - 2-3 days per week.
 - Never
 - No crew members are scheduled.
 - Only out of service times are during mechanical issues.
 - 40% of the time.
 - Approximately 5 calls/year (of their own) are uncrewed
- What is the average age of your EMS responders?
 - 30 – 45
 - 30 and up
 - 27-28
 - 40-45
 - 45-50
 - 45
 - 45
 - 35-50
 - 40
 - 40-50
 - 40



- EMT: 66 EMR/EMSVO: 75
- 45

Finance & Administration

- What are your primary revenue sources (billing, municipal contributions, grants, fundraising)?
 - Billing, grants, membership drive, fundraising, reimbursement from insurance, borough through Act 13 funds, small donations from other municipalities
 - Grants, fundraising, some billing, municipal in-kind
 - Pay per call, insurance reimbursements. No tax revenue is included. State EMS grant annually (\$15k). Annual membership drive is submitted into a savings account for operational/capital reserve needs. Donations go into savings.
 - Pay per call, annual membership drive, receive some donations. The annual membership drive averages \$10-12K.
 - Pay by call. Subscription drive generates roughly \$15k-20k. 15k from an annual state grant. 4k/year from one of the municipalities / \$500 from another.
 - 3rd party billing. Ridgway borough supports a 1mil tax. Township provides \$ from act 13 impact fees annually. Grant money for equipment.
 - 98% fee for service, fundraising, municipal support, subscription program
 - Fees for service. One municipality provides funding (\$200/year)
 - Billing, funding from UPMC, Kane Borough contribution
 - Billing for calls, membership drive annually
 - Pay per service, and a membership fund drive was established this year.
 - Pay-per-call. Solicit membership donations and a small fundraiser annually. (\$2000k from the fundraiser) (\$12-14k)
 - Pay by call. Receive grants. Fundraisers in concert with the fire department. Annual state grants.
- What percentage of billed revenue is actually collected?



- 60,163.60, contractual allowances 21, 902.26, 34,000.94 revenue received (one month)
- Unknown – look at the survey for this information. There is currently \$385K outstanding/uncollected fees. EMS agencies are generally showing outstanding income based on rates billed, not expected income ... Medicare, for example. Charged/billed rates were lowered to encourage self-pay or the balance of unpaid insurance reimbursement....most are more willing to cover the outstanding debts. Also calling patients/families and providing on-the-spot discounts to pay their debts so that they are collecting what they can from outstanding invoices/debts.
- 85-90%
- 75%
- 40-53% Typical split of allowable vs billed.
- 65%
- 60% billable (v. non-billable)
- 90%
- Unknown
- 70%
- Unsure. Uses a 3rd party billing vendor – maybe 90% - the amount is fairly high.
- Unsure – possibly 60%
- How do Medicare/Medicaid reimbursement rates affect your financial stability?
 - A lot of Medicaid, increase has helped
 - Medicare should reimburse more – rates are very fair. Medicare pays 50% of what is billed; 80% of the 50% is paid and the patient is responsible for the other 20%.
 - More funding on covered calls would help support
 - MA – until recently were only permitted to invoice mileage.
 - Yes. Representative Causer assisted with increasing Medicare rate reimbursement.



- 78% Medicare 9% Medicaid
 - Probably losing money when we take those calls. Regulated to take that activity.
 - The Medicaid increase was life changing.
 - Unknown
 - Unsure
 - MC – if they have a membership, they write off 100% of what is uncollected.
- What is your annual operating budget, and is it sufficient to meet current needs?
 - 599,953.21 – actual income 684,719.79 – operating within budget
 - \$871,000/year
 - Unknown. Budget is sufficient to cover annual costs.
 - \$250,000. “Holding our own” Last year expenses were \$252k and revenue was \$260k
 - \$830,000. Roughly a \$60k deficit.
 - 1.6 mil – meets needs
 - Bare bones - \$2.3M. Cost of personnel, benefits, workers' compensation, and wages drive most of the costs. Still missing calls, so the budget is insufficient to provide enough crews to capture every call for service.
 - \$1.1M \$133.00 per service hour – Operating at a deficit.
 - \$80,000. Yes, this is sufficient.
 - \$130,000.00 without capital costs. Yes, this is a sufficient amount.
 - \$130,000.
- What major capital needs (vehicles, equipment, facilities) are unfunded?
 - New ambulance, some equipment



- Units are replaced every 5 or so years.
 - No
 - Radio equipment and upgrades – priority need. Just purchased a new ambulance in 2024 that is 75% paid off.
 - None
 - Vehicles need to be replaced, building needs renovation
 - Need new stretchers; no power loads. Looking to replace at least 6 with costs of \$90k per each.
 - None
 - Yes – vehicles and facilities. Future planning for vehicle replacement – no building to house their trucks, currently.
 - Not now. A new ambulance will be needed soon – the current unit is 12 years old.
- What administrative burdens most impact your ability to operate effectively?
 - One person handles all admin, would like to have a secretary
 - Need another admin person – supervisor – to assist with QA/AI, Training.
 - No
 - There are not enough people to perform the functions.
 - No
 - None
 - Personnel issues, running down trip records, making sure people have things completed, scheduling is very time-consuming to constantly balance needs.
 - None. There is an admin and HR department.
 - QA and Training
 - Do not have an office person to handle the documentation and day-to-day requirements; responsibilities fall on the paramedics and EMTs.
 - All handled by one person – trying to keep on everyone to stay in compliance.



- What percentage of income is spent on salaries and benefits?
 - 60% of budget
 - 63% this year and 53% last year.
 - NA
 - Roughly 65%
 - 60-65%
 - 75%
 - Majority
 - 88%
 - 8%
 - Unsure, but believes roughly 42% of their income is used to cover salaries and benefits.
- What is the pay scale or hourly rate for employees?
 - Administration
 - 52K
 - \$100mo for maintenance / \$125 for payroll/ \$225 scheduling
 - \$65k/year
 - Paramedic
 - \$18
 - \$18.50/hr. base
 - FT SP – 23.25, FT P 22.25, PT 20
 - \$20-22
 - \$23
 - \$25/hour
 - EMT-A



- Will start at 21
 - \$17
 - \$17.50
 - \$18
 - \$21/hour
- EMT
 - FT w/o benefits – 18, FT w benefits 16, part-time 14
 - \$12
 - \$10
 - \$14.50
 - 16, PT EMT 15
 - \$17
 - \$15
- Driver
 - \$8
 - Paid by the call
 - 14
 - \$12.50
- Are there any benefit packages provided to employees, including paid time off?
 - Health insurance
 - Sick time off, simple IRA after one year of employment and match of 3%. Full time get 40 hours PTO along with self-scheduling and family scheduling. Health vision, dental insurance. Company pays all but 30% of health insurance. Free turkeys at holiday times.
 - No



- No healthcare, dental, vision, no paid time off.
 - Ft PTO, vision, dental, (100%) retirement (match 3%), health is covered at 100%, as well.
 - 100% premium and deductibles, short term, long term, 3% retirement – employee only
 - Annual increases, year-end bonuses (up to 3%), and cash gifts during EMS week and cash bonuses at Christmas. 1 week PTO 1-4 years of service; 15 years = 4 weeks, sick time accrual, STD, LTD, Healthcare, 4 PTO days/year.
 - Healthcare, Retirement matched at 4-5%, PTO
- Are there any incentives provided beyond the percentage of the budget?
 - Appreciation gifts: chairs, pizza party, small gifts/items.
 - The agency covers cost for members' needs: stethoscope, response bags, etc.
 - No
 - No
 - EMS week/Christmas comes directly from the board, not out of the EMS budget.
 - Paid training
 - Appreciation dinner, but it hasn't been done in year.
- What is the average cost per unit hour?
 - \$33/hour – wages only; no benefits.
 - Unknown
 - 114.5 als 107.26 bls
 - \$750/800
 - \$133.00
 - \$300
 - \$45/hour BLS /// \$50/Hour ALS crews.
 - Unknown



- What is the average cost per transport?
 - 500-700, up to 1500 on critical calls.
 - \$790
 - \$650/call
 - 5.52 per mile 5.18 per mile
 - \$175-\$200/hour...\$1000 per 5-hour transport.
 - Can't be factored without skewing.
 - \$750 base rate.
 - \$500-600
 - Unknown
 - \$30/fuel – unsure of other costs due to a combination of the department.
- What is the average amount collected per transport?
 - \$500 – as transfers increase, overall income decreases.
 - It depends upon the insurance; Blue Cross pays the full amount while others average \$500
 - \$650/call
 - \$432.00
 - Unknown
 - \$623.00 – cost is typically more than double the collected amount.
 - Unknown
 - \$1500-2000/transport
 - \$600 + \$15/mile “loaded”
- What is your payer mix (Medicare, Medicaid, commercial, self)
 - Primarily Medicaid and Medicare
 - 75-80% are Medicare / Medicare



- Unknown
 - Unknown
 - MC/MA (mostly) 10-15% are commercial insurance.
 - All
 - Primarily Medicare and Medicaid, about 11 or 12% commercial, small percentage self-insured/paid
 - Mostly Medicare. 60+%
 - Unsure
- Has your agency operated at a financial deficit at any time in the last three years? If so, how was the deficit covered? (Reserves, municipal, loan, other)
 - Yes – until 2025 before new manager
 - No
 - Yes – reserves from the prior year.
 - Yes – 60\$K. Agency has investments. Borough assists with reviewing and provides the tax mil....looking to increase the millage collected.
 - Yes – capital reserve fund
 - Yes . last two years. Using reserves and watching the budgetary numbers very closely.
 - Deficit covered by surplus in other stations, outside of the study region
 - No
 - No
- What is the average wage for EMT (starting vs. five plus years' experience)
 - \$14 ... AEMT will make \$16/hour
 - \$10/hr – no raises applied in the past few years.
 - Employee evaluation \$ 4-5% annual increase if approved in the budget.
 - \$15 to start - ~\$3 difference



- What is the average wage for a Paramedic (starting vs. five plus years' experience)
 - \$19
 - Employee evaluation \$ 4-5% annual increase if approved in the budget.
 - Less than 3 years experience makes 1 less
 - \$23 to start ~\$3 difference
- Have you lost staff to hospital or other health care employments?
 - 1 person in the last four years ... left to take a management level position.
 - No
 - Yes – better opportunities.
 - No
 - Yes
 - Yes
 - Paramedics have left to work at a hospital.
- How many staff have left EMS entirely in the past three years? Reason?
 - As above
 - None
 - Yes – one retired at 70+ YOA
 - None left EMS entirely.
 - No
 - 10-15 younger staff who moved into their degree field of employment.
 - 5 - unknown

Regional Collaboration & System Coordination

- How do you coordinate with neighboring EMS agencies?
 - ALS agreement, EMS managers are talking about sharing staff



- Through the captain, through the county
- No communication whatsoever with BLS services. When they go out of service, they only inform the 911 service, and those do get announced twice a day.
- Normally, if the agency is out of service, we will inform the county dispatch center, no coordination with the neighboring EMS agency.
- The agency coordinates with some while others are lacking.
- Neighboring agencies maintain awareness of other agencies and will self-move up to a “center point” to cover the area. 2nd call tone out for a period and the neighboring agency will take the other calls.
- Yes
- Relationship with [other services] and training institute. Collaborating with other BLS services; merged and paid staffing one truck between areas.
- PSAP
- No coordination exists
- Ok – would be better with more communication.
- Make sure the neighboring agency is aware if this agency cannot crew. Attend the [adjacent] county agencies. I have met with neighboring agencies to discuss a regional collaboration.
- Always covering the neighboring departments – the agencies do not always notify this department when they are not available.
- What mutual aid agreements are in place, and how often are they activated?
 - St, Marys, Ridgway, Renovo
 - Used to have with Emporium and Austin
 - Yes. But they were written years ago when staff were abundant.
 - No
 - None
 - Yes, with all the local services for both mutual aid and billing agreements.



- Not signed agreements.
 - None
 - Yes – assisting with coverage as dispatched.
 - Yes – activated with second due services.
 - Yes – with multiple departments ... four surrounding jurisdictions.
- How effective is communication with county 911 centers?
 - For the most part
 - Depends on where you are, lack of coverage
 - ~90% - still have a few holes in coverage.
 - Very good.
 - Not bad – some upgrades throughout the years. Issue with responding into Indiana Co (800MHz) with a gateway, but it is not implemented to share communications.
 - Good, but there is not always a good understanding of how EMS operates.
 - Ok
 - Effective. Getting information in a timely manner is sometimes difficult.
 - Communication is good – meet once a month with the association.
 - Do not receive sufficient information from dispatch. If information is passed through a second PSAP, delays are introduced and the information is not completely relayed.
- What regional challenges could be solved through shared services or joint planning?
 - Potentially sharing staff
 - Used to have joint planning, should talk more, poor communication between services
 - The agency met with the county 911 to determine how to handle calls for service not crewed; one meeting occurred, but no more have been scheduled – the original meeting occurred sometime last year.



- Considering a shared services agreement with a neighboring EMS agency for shared staffing /pooling of resources.
- Maintaining situational awareness – difficult when thinking about out of county resources.
- Staff sharing would be beneficial
- Proponent of sharing people. It needs time to get to the next level of figuring out all the logistics.
- None
- The state recommended this (sharing/coordination) previously, but the idea was not widely accepted by most. The distance and time frame working with other service – due to the area covered. Limited resources cannot cover the primary area let alone a much-expanded area.
- Unknown. Possibly shared staffing *might* help, but unsure.
- This has been a topic of discussion among several agencies. Because of the response area, it is very difficult to plan what coverage would look like for the area/region. Discussions with the township supervisors have been held to institute a fire or EMS tax. Municipalities are going to have to step up if that model is pursued.
- What governance or regional framework would best support your agency?
 - Will never work in [this] county. Remove the pride and prejudice out of assigning calls and dispatch based on location of EMS agencies. If we were all paid services, it could be easier to dispatch by location. With many BLS services, you do not know what crews are available. It would be good if EMS could become part of the tax revenue stream to assist with funding. Need to have better planning and coordination with the 911 center regarding pre-plans for dispatches. Do not need to send an EMS unit to trees down type of calls. No good coordination among responders when different fire stations want different response plans for the same event type.
 - State funded / guided service coordination would be helpful.
 - Regionalization may happen but do not believe it will occur in the near future.



- Some type of authority needs to be configured in the proper way. Everyone needs to be “at the table” get it set correctly and operationally.
- None
- Unknown
- Unsure what would work best if moving to a regional. Some oversight body to provide input for the municipalities and agencies, but unsure which one makes the most sense.
- Don’t do the “sharing thing” we just take the call
- Inter-agency coordination (among themselves) would help vs an EMS Authority or COG type of model.

Strategic Needs & Future Planning

- What are the top three changes that would most improve EMS in your county or region?
 - Higher reimbursement, national registry, requirements
 - More EMTs, Drivers only needing EVOC, more collaboration between entities
 - Increased funding. Increase Medicare reimbursement slightly and add ½ mill or 1 mill tax would provide a little extra funding. Millage should be the same across the board throughout the Commonwealth.
 - Aligned protocols
 - Recruitment and retention.
 - Obtain more staffing, more funding to provide service and enhance response.
 - More people – not enough available to cover the agencies. Hearing rumors that EMSVO will be removed at the end of this year and will likely put their agency out of service.
 - Additional coordination among agencies; awareness of out-of-county calls. Can view some of the agencies through the Northern Tier – would be helpful if agencies could view the shared data via mobile CAD.



- Increase in reimbursement
- Financial, more staffing available
- Funding. Training. Long-term planning / building partnerships.
- Funding model, community need based EMS – review municipal boundaries and change dispatch to closest, most appropriate service, understanding of and reduction in time on task, EMS becoming a county instead of municipal responsibility.
- Have funding available to pay staff members. More volunteers.
- A better effort to provide training in the rural areas for those who want to volunteer have an easier time attending training. A change at the DOH – not relax the standard for rural EMTs – but adapt the need for rural EMS providers. Sometimes, there are only EMRs available – we simply need to get people in the ambulance and get them to the facility.
- Incentives for people would help. Don't know how to attract more people. Perhaps easier access to EMCO West – get different answers from different people on the same issue/challenges. One person is excellent – one other is absent due to health – do fine at their level; above them, there are people that are not accommodating. “We” don't see anyone face to face.
- What innovations or models (e.g., tiered response, regional staffing pools) interest you?
 - City of Pittsburgh – 2 ALS with minimal BLS trucks. City of Boston staffs mostly BLS crews and minimal ALS trucks. What are the outcomes at the 30, 60, 90-day outcome, and the differences are the same or comparable.
 - Unknown
 - Regional shared services.
 - Local agencies have begun discussions on staffing pools to share resources.
 - Staffing pools
 - Authority model. Reynoldsville/Sykesville sharing of people.
 - Shared personnel / staffing pools availability.



- Having more paramedics available is needed – not a lot of access to paramedics. Staffing pools – “not allowed” to assist other agencies from a state level.
- Duly enrolled staffing with other agencies.
- What support do you need from counties, municipalities, or the Commonwealth?
 - Funding
 - More frequent training, fewer required hours, no national registry, or optional
 - Local officials need to be educated about what they are responsible to provide. Center County holds classes for newly local elected officials regarding what they are responsible to provide but does not happen here. Decisions made today affect responders for years to come...capital decisions, for example.
 - County Commissioners have a better understanding of EMS since they are full-time.
 - State legislators at times are unfamiliar with previous legislation. Need to meet regularly with state legislators.
 - Figuring out how to recruit and retain more volunteers and determine a reliable funding stream for EMS.
 - Funding is needed. Expenses have increased but reimbursement has not increased.
 - RE: staffing pool, working through the logistics of insurance coverages, employment, supervision.
 - Lobbying, advocacy, financial assistance, municipal education
 - Needs to be education done for local government to understand what we do and how they should be involved, including funding requirements.
 - None
 - Assistance/financial aid from the Commonwealth would help support availability. From the county, radio communications are lacking – went to P25, and communications in the area is not as anticipated.



- Continue discussions on how to solve the issues. Everyone is aware of problems in rural EMS, and we need to keep the dialogue open. Every policy / procedure that comes out further complicates things and discourages people from volunteering. The municipalities may not understand what a fire/EMS tax is, how to institute it or how they can spend it; they do not understand how to recruit people. There needs to be an educational document/course for [elected officials].
- Financial support from the Commonwealth would be very helpful. Difficulty in obtaining financial support in the rural areas; counties need to support EMS agencies and step in – provide a pension program or other incentives.
- RURAL EMS – 2-4 hours away from a trauma center, and if the helicopter won't fly, it takes 4 hours. Take the pt to the closest hospital, instead.

Open-Ended Input

- What issues have we not asked about that you believe are critical to EMS sustainability?
 - No
 - Nothing beyond what you asked.
 - Need to get/keep people interested, be able to pay a competitive wage, and assist with more people passing the EMT test.
 - Limited staffing pool/candidates can be a struggle.
 - When to Work application is currently in use for scheduling.
 - Recruitment and retention, but also recognition – not just ambulance drivers – **we are part of the healthcare system.**
 - None/unknown
 - Staffing – neighboring agencies claim to have staffing but cannot crew. If we could return to the original test and not use the NR test, it may help with certification of more people; NR is not used in the middle part of the state.
 - Being able to recruit and make being an EMT more appealing. Possible development of a rural EMS course
 - More support and understanding from the commonwealth level. Once EMT cert expires – having a grace period to re-enroll and catch up on changes would be



helpful. Finally starting to get classes available in the area to do the hands-on con-ed. Con-ed should be dynamic – if you run a lot of trauma calls, then con-ed should be medical focused and vice-versa.

- What else should the region understand about your agency's challenges or strengths?
 - No
 - They need to understand that we're volunteers and people have other jobs and personal requirements.
 - Keeping EMTs engaged is very difficult. Need to come up with incentives to retain staff. Need to be recognized – recognition through EMCOWest for most calls, etc. (State campaign as part of marketing). Strengths – always covering neighboring departments and their own calls.
 - Shared issues: staffing across the region, state, and country. Funding – shortages nationwide. Movement from state government and legislative changes.
 - We have equipment, trained personnel, and vehicles, but not enough people to staff around the clock.
 - Demand is increasing. More agencies ending services altogether that places further strain on the existing agencies to cover the calls.
 - Our region is pretty well aware of the challenge: finding people to volunteer. Even if the agency could pay, there are no individuals stepping forward to fill those positions.
 - I would love to have more communications between the agency, the state, EMC West, and have more meetings opened up to all people, not just chiefs. At least once a year county-to-county.

Additional Comments

- Smaller areas need better communication, very rural areas, not enough people, and need to work together. Some departments don't work together.
- There are a lot of camps and few full-time residents.



QRS Interview Packet

Recruitment & Retention

- Describe your current QRS staffing model (career, volunteer, mixed)
 - Volunteer
 - Volunteer
 - All volunteer
 - Volunteer ... 11 first responders.
- How many personnel are certified to provide medical response?
 - 39
 - 27
 - 13 Firefighters active, all have CPR/FA/AED
 - 5 EMS certified and an additional 12 CPR only.
 - 11 first responders – 8 EMT, 3 EMR
- What challenges do you face in recruiting new QRS responders?
 - No one wants to take the time to go to the classes, cost is too high, and no one wants to travel the distance to the classes.
 - Young kids do not want to volunteer. Time commitment.
 - Difficulty getting people to volunteer and not a lot want to attend the EMS training.
 - Township is 57 sq miles and 1500 residents. Northern part of the township is “aging out” and not a lot of individuals to pull into the service.
- What factors most affect retention of medically trained fire personnel?
 - Most have been in place for a considerable amount of time. All keep up with con-ed. Instructor in their dept put on training sessions (con-ed) weekend.



- The job market in the area is not enough to keep them local so they're available to the department.
 - They all have jobs/careers.
 - All but 2 responders have been there for 10+ years.
 - Society is so different and kids just don't want to do it anymore
- How do competing demands (fire, rescue, EMS) impact staffing availability?
 - None
 - The department will divide and conquer to ensure the QRS unit responds.
 - No impact.
 - Majority of the calls (1/2 plus) are medical calls. Not really a struggle. 220+ EMS calls/year. Busy enough to hold interest, but not too busy to burn out the responders.
- What incentives, financial or non-financial, help keep responders engaged?
 - The fire department covers the cost of training. Calls tallied at the end of the year...if they make 10% of the calls, the department offers clothing items.
 - The department pays for the EMR/EMT classes.
 - [They do] % tax relief for active members that meet a threshold
 - The department pays for responders to take EMR or EMT Classes.
 - Department picnic annually. Attempt to incorporate as many as possible during public events. Family gets to witness achievements of personnel. Provide uniform/clothing items. Sunday breakfast for department staffing only.
- How has your staffing level changed over the past 3–5 years?
 - Stable – lose a few and then a few will volunteer. Concerns over the average age of the responders. Some of the younger staff are getting ready to leave for college.
 - Has not grown; staffing remains stable. 2-3 run 90% of the calls.
 - Decreased dramatically



- There has been a decline due to the lack of volunteers. Vol. are aging out and younger people are not stepping up.
- Added two additional QRS responders.

Training & Certification

- What medical certifications do your QRS responders hold (EMT, EMR, paramedic)?
 - None
 - CPR Only
 - 18
 - 12
 - 12
 - EMSVO
 - 6
 - 8
 - EMR
 - 7
 - 1
 - 3
 - EMT
 - 8
 - 5
 - 8
 - 5
 - A-EMT
 - 0



- 1
- EMT-P (Paramedic)
 - 0
 - 0
- PHRN (Prehospital Registered Nurse)
 - 0
 - 0
- PHPE (Prehospital Physician Extender)
 - 0
 - 0
- PHP (Prehospital EMS Physician)
 - 0
 - 0
- How do you support initial certification and continuing education?
 - Dept pays for their classes. Weekend con-ed sessions from time to time. Reimburse meals and fuel if they need to travel out of time.
 - Pay for classes. The department schedules continuing education at the station when they can. Several instructors in the area provide classes. Members can use station internet to do online con-ed. Pay for training and mileage.
 - Pay for initial classes for responders. Encourage staff to continue taking their con-ed.
 - Department fronts the funding for EMT classes; 2 went this year ... they will reimburse one and the other obtained the funding initially. **If training is not completed, they must repay the department. Dept. does not fund food or lodging.



- What barriers do members face in completing required medical training?
 - Having the “drive” to go and take the test. Classes used to be held at designated departments, and now the candidates need to drive to testing sites. [We] need to go back to older, proven methods of testing.
 - Having a job outside of the department that conflicts with their duties.
 - Time available to take the classes.
 - 3 of the staff went, 2 failed, and 1 completed/passed. The two that failed struggle with written testing; practical skills are great. **Instructors do not convey or instruct on test taking “skills”
- Do you have in-house instructors or rely on external training centers?
 - Yes
 - Several instructors in the area provide classes.
 - In-house instruction, but no official courses.
 - Nothing in-house.
- How do you maintain competency in medical skills given call volume and staffing?
 - Most are good with keeping up with their CPR, AED refresher, and continuing education.
 - Responders do critiques of “odd” or serious calls. Infrequently used equipment refresher training. Monthly checks on the trucks...keep up to date on how to use and where to find equipment.
 - Through maintenance of continuing education.
 - Staff routinely run calls and perform skills. Members participate in continuing education. When new members are onboarded, the department performs internal training to a level of truck familiarization and location of medical equipment.
- What additional training resources would strengthen your QRS program?
 - Unknown
 - No QRS agency



- More online training would be beneficial. Symposiums would help responders with ongoing training. More frequent trainings in county or adjacent counties.
- The state has done a good job bringing additional classes online. For QRS , there are not a lot of funding opportunities available to assist the department. EMSOF funding went away.

Operational Rhythm & Service Delivery

- Describe your QRS call volume and trends over the past 3–5 years.
 - Average 50-60 calls per year.
 - 2023
 - 109
 - 119
 - 2024
 - 102
 - 90-100
 - 120
 - 2025
 - 77
 - 90-100
 - 125
- What types of medical calls does your QRS unit typically respond to?
 - Charlie, Delta, Echo calls unless there is a special request.
 - Charlie/Delta/Echo calls
 - Bravo level calls and above.



- The department is dispatched on all medical calls.
- What is your average turnout time for QRS responses?
 - 5 minutes
 - 4-25 minutes [We] cover 160 square miles, state park and 4 townships.
 - 8-10 minutes
 - 8-10 minutes
- How often does your QRS unit arrive before the transporting EMS agency?
 - 95%
 - Most of the time.
 - Varies most of the time, but typically 5 minutes prior to EMS.
 - 50-60% of the time, the department arrives prior to EMS.
- How do you coordinate on-scene roles with EMS providers?
 - 2-part QRS report under assessment shared with EMS. Department continues to assist EMS while on scene.
 - When EMS arrives, QRS will continue care while the other gives a report and provides the written PCR. Assign tasks/roles to the responders to make the call run as smoothly as possible.
 - QRS coordinator. Fire on scene first does the initial assessment and provides support to EMS.
 - If EMS arrives first, the QRS will support the call. If QRS arrives first, they initiate patient care and will continue to support the BLS/ALS crew however throughout the on-scene call. EMS crews will only cancel QRS if they begin transport prior to QRS arrival.
- What equipment do you carry on QRS apparatus, and what gaps exist?
 - Everything required. This department is currently putting a new response vehicle in service.



- Resuscitation bag, AED, airways, BVM, suction, glucose monitor (required), and immobilization, KEDS, splints. GAPS: Trying to outfit all apparatus with bags of equipment.
 - AED updates and supplies are expensive
 - Standard BLS supplies. This department is pretty good with equipment. We just purchased new AEDs.
 - All licensed equipment required. Carry: backboards – basic items. Gaps: AED – current one is pushing 5 years old; battery replaced last year at \$~600.00.
- What operational challenges most limit your ability to provide timely QRS response?
 - Daytime and manpower availability.
 - happening; family care. Limited drivers for the apparatus. Oxygen tank refills – local EMS service used to allow for swapping cylinders, but recent management changes do not always allow for exchanging cylinders.
 - Staffing/lack of staffing. Covers Clarion County, too. Clarion takes longer / delays in getting the message to Jefferson County to dispatch.
 - Staff respond from home, limiting the time. Evenings are better due to personnel at the station most evenings.
- How do fire suppression or rescue incidents affect QRS availability?
 - No
 - No
 - Different call types help to hold the interest of the department personnel. On average, only one to two incidents annually occur where the department is on a fire or rescue call and cannot break staff free to run the QRS response.
 - If the department is on an incident, the front-line firemen are unavailable to respond to EMS incidents. Rarely occurs.



Finance & Administration

- What is the annual cost of operating your QRS program?
 - \$2500
 - Budget is not broken out by fire, rescue, QRS.
 - Only one budget; unknown. Allot \$4,000 out of the budget.
 - Budget is all together with fire responses. EMS provides replacement supplies and equipment.
- What funding sources support QRS operations (municipal, fundraising, grants, fire tax)?
 - Municipal tax millage(0.5m ~\$10,000), donations, grants, fundraising.
 - ½ Mill fire tax – dedicated to new fire hall.
 - General donations. Receive fire aid from the municipalities. No fire tax.
 - Municipality provides fuel – there is a 2mil fire tax for the department. Fundraisers and donations, as well as the state fire grant. AFG grants are selectively applied.
- Do you receive any financial support specifically for medical response?
 - No
 - \$4,000 allocated out of the annual budget. Sometimes, a family will donate earmarked for QRS.
 - No
 - No direct funding.
- What in-kind support do you receive (fuel, facilities, utilities, insurance)?
 - Municipality covers workers' compensation
 - Township provides workers' compensation insurance.
 - None
 - Fuel, workers' compensation. Department pays for their own insurance, utilities.



- What major equipment or capital needs are unfunded (AEDs, bags, vehicles)?
 - None
 - A new rescue vehicle.
 - None
 - AEDs, QRS unit is a 2012 vehicle, just over 20K miles.
- How do administrative requirements (reporting, QA/QI, training records) impact your agency?
 - All calls go in the fire reporting records. Detailed reporting software would be helpful.
 - A few of us make sure all reports and equipment checks get done.
 - QRS sheets are completed; nothing else impacts the operations.
 - Department is transitioning to electronic record keeping. It would be nice if the department of health would allow for electronic record keeping vs paper copies. State should pick up the costs for e-charting.
- What financial challenges most threaten the sustainability of your QRS program?
 - Unknown
 - Vehicle maintenance.
 - None
 - Simply, rising cost for everything.

Regional Collaboration & System Coordination

- Which EMS agencies do you most frequently interact with on medical calls?
 - Jefferson EMS, Sykesville/Reynolds, Dusan
 - Brockway, Ridgeway, Fox Township
 - Jefferson Co EMS, Clarion Hospital EMS.
 - Clarion EMS, Jefferson EMS.



- How effective is communication between your QRS unit and EMS providers?
 - Communication is pretty good.
 - Pretty good.
 - Good
 - Communication with Brockway is very good. Response and on-scene coordination are good due to everyday familiarity with crew members.
- Do you participate in county or regional EMS/fire coordination meetings?
 - Fire Chiefs' quarterly meetings.
 - No ambulance associations. County fire chiefs meet quarterly that this department attends.
 - Do not have any.
 - Yes – Fire Chiefs and EMS Association meetings.
- How well does the 911 center support QRS dispatching and situational awareness?
 - No issues – sometimes information flow is slow.
 - Seasoned dispatchers do a good job; new ones need some work that will come with time and practice.
 - On the Jefferson side, it is very good.
 - Department just switched to being dispatched by [another] county. When dispatched by [one] county, if [the] ambulance was dispatched, the PSAP would not dispatch the QRS service.
- What mutual aid or automatic aid agreements affect QRS response?
 - No
 - No official agreements are in place.
 - On box alarms for certain areas. Depending on the nature of the call it tells us what services are coming from neighboring departments.
 - No



- What regional challenges could be addressed through shared services or joint planning?
 - Reynoldsville/Sykesville shared services. Service is paying one crew to have staff available.
 - Sharing staffing availability could assist with planning and coordination among services.
 - There is a lack of manpower to staff ambulances. The normal ambulance is Clarion that was tied up, and Brookville, their backup was tied up, a third level ambulance was responding – helicopter did not lift for nearly two hours. Could fix extended area response with joint planning.
 - Unsure
- What governance or regional framework would best support QRS operations?
 - When EMS stations are tied up on calls, using QRS services to fill in/cover patient care until the EMS units can “catch up.”
 - More departments are consolidating for personnel reasons.
 - Reimbursements
 - If the state could provide funding for training or incentivize attending continuing education, that would be very beneficial.

Strategic Needs & Future Planning

- What are the top three improvements that would strengthen QRS service in your area?
 - Finances, financial assistance. Several people belong to other departments or are further away from the station – would be good to have more people closer to the station for responses.
 - Assistance with training – funding. Equipment upgrades (AED) or software for patient care forms. Expiring expendable meds, materials – the department cannot afford to replace the expiring items simply based on the exp. Dates.



- If more surrounding departments operate QRS services; some never had while others lost their service.
 - Additional staffing/volunteers. Additional funding from a sustainable source. Reimbursement for training and con-ed.
- What innovations or operational models (e.g., integrated EMS–fire response) interest you?
 - Unknown
 - Intra-nasal EPI – if that could be included in local protocols, not cost as much and have a short life....expiration.
 - None
 - Viewing the responses to medical and fire calls as continuing to support and care for the community. The Commonwealth would be much better served with integrated fire/EMS combination services...fewer buildings, fewer apparatus. Not sure how practical that model is, in general.
- What support do you need from municipalities, counties, or the Commonwealth?
 - Financial support is #1. Department owns everything – blacktop needs to be replaced, but there are no funds to cover 100k, for example.
 - Reimbursements and grants. QRS does not bill for services.
 - Funding from the commonwealth for software and equipment. The township is very supportive of the department. The department provides a monthly budget report.
 - More tax relief
 - Financial support for on-going education.
- How do you see the role of QRS evolving over the next 5–10 years?
 - Unsure. If things don't change, there will be no one available to run calls: aging out, moving away.
 - Rural EMS services will increase their call volume. More burden will be placed on QRS services.



- QRS services will continue to be busy until the EMS entities are supported better.
- Lack of personnel
- Due to the lack of EMS personnel, medical responses will rely more on QRS responses. QRS agencies do not have the resources to cover the gap without assistance.

Open-Ended Input

- What issues have we not asked about that you believe are critical to QRS sustainability?
 - Financial. EMR/EMT programs are a little too long.
 - Trying to figure out how to get people to volunteer.
 - Some of the [legislators] do not completely understand the role of rural EMS response, instead focusing on city-based EMS due to the population/makeup of the cities. The cost/benefit of spending dollars on cities looks better, but [they] do not understand the rural response system.
 - Covering too much when no EMS units available
 - None
- What else should the region understand about your department's medical response role?
 - The department has been operating for 35 years. Numerous CPR saves. Large Amish community that does not know what to do in medical emergencies.
 - The amount of time it takes to arrive at the scene based on the coverage area.
 - Nothing
 - If they want the department to continue training staff, the curriculum needs a deeper dive Unknown if the National Registry curriculum, test, or training centers are problematic. The new role-out issues are expected, but when the problems continue, there needs to be a much closer look at why only a handful of responders are able to pass the exam. (This department sent 10 and only 3 passed in a recent class.)



- Is there anything additional you want to share about QRS operations in your community?
 - Have great people in place. May spark interest if there were some reimbursements to help cover the costs and get more staff to take EMR/EMT classes.
 - No
 - We do the best job we can with what we have here. Need to motivate the public to want to help. More education on end-of-life encounters, better understanding on DNRs – what can responders accept.
 - No



Municipal / Elected Leader Interview Packet

(Awareness of EMS obligations, financial support, legislation, agency relationships, and local expectations)

Awareness of EMS Responsibilities & Legislation

- How would you describe your municipality's role in ensuring EMS coverage?
 - Make donations to service
 - Make donations to service, no contract
 - No role
 - EMS is provided through the municipal fire department.
 - Contracting with a service provider – St. Marys Ambulance Service. St. Marys Ambulance is a privately owned entity in the City of Saint Marys, not a municipal EMS service.
 - Make donations to service, no contract
 - The county does not have any municipal level responsibilities, although they are looking at pursuing an EMS authority model, as is being looked at in another county.
 - Strong QRS service in town
 - The municipality provides the minimum. Supervisors are unsure why they need to pay for EMS coverage services; they are accustomed to fire department being self sufficient
 - Ambulance arrival is difficult to ensure. JEMS is primary and Clarion second
 - Pay for workers' comp, and paid insurance on trucks and vehicles
 - Make donations to service, no contract
 - Twp board member on ambulance board
 - Contracting with a service provider – [...]. [The] ambulance is a privately owned entity in [the] borough, not a municipal EMS service.



- Are you aware of Pennsylvania legislation related to municipal EMS responsibilities?
 - Yes
 - Yes, primary service assigned to Emporium EMS
 - Yes
 - No
 - Yes
 - Yes
 - Yes
 - Yes
 - Yes
 - Yes
 - No
 - Yes
- Are you familiar with Act 7, Act 17, or other EMS-related statutes?
 - Yes
 - Yes
 - Possibly, the statutes, but not the specific numbers/titles
 - Yes
 - Yes
 - Yes
 - Discussed the impact on the dispatch staff, and the agencies do not provide information when the EMS providers are unable to staff calls.
 - Possibly, the statutes, but not the specific numbers/titles



- Do you believe your municipality is meeting its statutory obligations for EMS?
 - Yes, minimally.
 - Yes
 - Yes
 - Familiar that municipality must provide the service
 - Yes
 - Yes, minimally.
 - Yes
 - Yes
 - Yes
- How do you stay informed about EMS issues affecting your community?
 - Through the commissioners' office
 - Monthly
 - The township has a representative on the board. Reports would be provided if requested.
 - Meetings, on ambulance board
 - Meetings, on ambulance board
 - Word of mouth, keep eyes/ears open. No direct communication with the agency.
 - Yes, participates in meetings
 - From [our] level, we are not overly aware of the issues affecting the EMS agencies.
 - Municipalities do not want to fund EMS, for the most part, through raising taxes or willingness of the municipal leadership. Others are unaware the services are struggling.
 - Township supervisor sits on ambulance board of directors
 - The borough has a representative on the board. Quarterly reports are provided.



- The fire chief is the president of the board of supervisors for [the] township.
- Came to a meeting
- [He] is president of department

Understanding of Local EMS Operations

- Which EMS agency or agencies provide service to your municipality?
 - Sinnemahoning, Cameron County, Austin, Karthaus, Clinton County
 - Cameron County
 - Wilcox Fire Department
 - Cameron County
 - Emporium EMS
 - Ridgway Ambulance. County 911 determines second, third, etc. due.
 - Cameron County
 - TLC EMS
 - Sinnemahoning Vol
 - Ridgway Ambulance
 - Cameron County
- How would you describe your working relationship with those agencies?
 - Good
 - Good
 - Excellent. They do the best they can do.
 - Good. We only hear from them when they need money.
 - Good
 - QRS is strong but there is no communication with the ambulance
 - Yes



- Good
 - Good
 - Cordial. No open dialogue between the EMS agency and the municipality.
 - Good
- How often do you communicate with EMS leadership?
 - Not often, some awareness just through community connections
 - Monthly
 - Monthly communication
 - Monthly, representative on board
 - As needed
 - Monthly
 - Frequent with QRS provider but none with EMS providers
 - Only through individual contact / personal contact communication.
 - Board member reports monthly to Township officials.
 - Quarterly
 - Often, in small communities, everyone helps
 - Monthly, representative on board
 - Monthly, representative on board
- Are you aware of their staffing levels, response times, or operational challenges?
 - No, only if dispatched and do not go on route
 - Yes, a little
 - Always understaffed
 - Halfway units and extended times for mutual aid departments
 - There are personnel challenges.



- Yes – personnel is biggest
 - Yes
 - Licensed ALS with one part-time provider, and a skeleton crew for other responders.
 - Additional volunteers are always beneficial, but the service operates very well.
 - They do the best they can with the resources they have
 - Personnel/Staffing
 - Yes, primarily personnel
- Do you receive regular reports or updates from EMS providers?
 - No, but they would provide if asked.
 - Yes
 - Monthly
 - Nothing. If asked, unsure how the agency would respond, and there is skeptical opinion on whether the information would be factual or accurate.
 - No
 - Yes, monthly
 - Monthly
 - Quarterly
 - No but we are aware of what is going on
 - No, was provided with a financial report on request

Financial Support & Funding Mechanisms

- Does your municipality provide direct financial support to EMS?
 - Donation
 - Monetary – tax levy
 - Not to EMS, Fire department/QRS yes



- Donation to Cameron County – back up service
 - Monetary – tax levy 1.5 mil
 - Donation
 - Donation, Act 13
 - No
 - No. The services is an incorporated, for-profit agency.
 - No tax dollars or assigned millage
 - Make an annual donation/contribution
 - Monetary – tax levy
 - Donation
- If yes, what is the annual dollar amount?
 - Varies
 - Approximately \$20,000.00
 - About \$25,000 from Act 13
 - Varies
 - Donation that varies.
 - Not stated
 - Approximately \$40,000.00
 - Not provided
 - Varies
- What form does support take (appropriation, contract, subscription purchase, donation)?
 - Donation
 - Contract
 - Donation



- Contract
 - Contract
 - Donation
- Do you provide in-kind support (fuel, facilities, insurance, utilities, equipment)?
 - No, but would if asked
 - No for QRS and EMS
 - Worker's Comp., vehicle, and building insurance
 - Fuel if needed, workers' compensation insurance, snow plowing
 - No
 - No but would be open to discussions
 - No
 - No
 - No, but would if asked
 - No, but would if asked
- If yes, what is the estimated annual value of those contributions?
 - NA
 - NA
 - NA
 - \$1,600.00 insurance \$1,500.00 split between 3 municipalities
 - NA



- Do you levy any taxes or fees specifically to support EMS?
 - No
 - 1.5 mil
 - No
 - No
 - No
 - No
 - .5 mil
 - No
 - No
 - 2 mil
 - No
- Have you considered implementing EMS cost-recovery ordinances or subscription programs?
 - No
 - No, don't know what it is
 - The township does not. [The] ambulance has a subscription program.
 - No
 - No at the borough level, but fire department does subscriptions
 - Discussions but no actions
 - The borough has a cost recovery ordinance. [They have] a subscription program.
 - No
 - I am willing to consider guiding toward an EMS authority model, but I believe it will be difficult to begin formation.
 - Yes



- No
- What financial challenges limit your ability to support EMS?
 - Low budget
 - For-profit status of the EMS provider. (No contract with the municipality as a for-profit)
 - Budget. Will find funds if Act 13 goes away
 - Budget
 - Small municipality with no business. Municipal population is less than 400
 - None
 - If Act 13 monies dry up it will become more difficult to support the service.
 - Rural small municipality
 - Budget restrictions, low millage
 - When Act 13 is gone
 - No limitation

Expectations & Service Delivery

- What are your expectations for EMS response times in your municipality?
 - 10 minutes
 - 10 -15 minutes
 - 10 or 15 minutes.
 - No expectation
 - Expect 10-15 but realize that's not always realistic. Reality is 20 minutes or more
 - Five to ten minutes
 - 10 -15 minutes
 - 10 minutes



- Responders to the best of their ability
 - Ten to fifteen minutes
 - 7-10 minutes dispatch to response.
 - 10-15
 - 10-15 minutes if there is coverage, up to half hour if not
- How satisfied are you with current EMS performance?
 - Very
 - Very
 - Very
 - EMS agency response is minimal, and satisfaction is meeting basic expectations.
 - Very
 - Satisfied
 - Very
 - Very
 - They do the best they can
 - Very
 - Very
- What concerns have residents expressed about EMS service?
 - None
 - None
 - Amount of time it takes to get there
 - Yes, response time
 - Nothing specific noted, just general complaints
 - None



- None
- 911 has received calls inquiring what is taking EMS “so long” to respond, and the information is forwarded to the EMS service to answer/respond.
- No
- None
- Concerns about the service closing
- None, to date, but it is unknown if the residents understand what expectations should be for EMS response.
- What improvements would you like to see in EMS operations or communication?
 - None
 - Long range plan, fiscal responsibility
 - Personnel, state pay
 - Show professionalism in response.
 - For EMS to have crews available to respond.
 - They do the best they can
 - Radio enhancement completed are appreciated.
 - Units kept indoors. Meet basic EMS regulations/ requirements.
 - Better response times with manpower
 - None
 - New and younger personnel
 - Fiscal responsibility, service wants to go back to ALS and it will be too expensive
 - Meet basic EMS regulations/ requirements.
 - Consolidation through the county – countywide service



Regional Collaboration & Planning

- Are you aware of regional EMS challenges affecting your municipality?
 - Personnel
 - Personnel
 - No
 - Personnel
 - Personnel
 - Staffing
 - Personnel
 - Everything – there is no one to call.
 - Personnel
 - Personnel
- Would you support a regional EMS authority, shared services model, or joint funding approach?
 - Yes
 - Don't know about support but think it will go that way
 - Yes
 - Yes
 - Yes, to form an authority. The concern with shared services is with burnout of the membership. Sharing of resources is a good concept in a temporary solution / interim solution.
 - Yes. A specific number of units available to respond, strategically located, and under contractual obligations.
 - Yes
 - Possibly, but fears of increased costs and price gouging
 - No



- Yes
 - Yes
 - Yes
 - It would need to be voted on
- What barriers do you see to regional collaboration?
 - Expenses/funding
 - Expenses/funding, everything will go to [one agency] and [their] County
 - Municipality would not be willing to commit the funds required, and they would not understand the reasoning behind the requirement.
 - Residents won't support
 - Rural PA Municipality
 - Pushback from the municipalities.
 - None
 - Change is difficult. The services and municipalities are already working together.
 - Physical location
 - Expenses/funding, response time
 - Our concern would be a decline in the quality of service. Responders who don't live here will not treat patients in the same way. Response times could increase depending on where EMS is stationed.

Open-Ended Input

- What additional information would help you better understand EMS needs in your community?
 - None
 - None
 - No



- Healthcare needs a place at the table in any combined services discussions; not to privatize the services.
 - Recruitment and retainment of EMS personnel
 - None
 - Instruction for EMS volunteers and maintaining certifications
 - Nothing
 - None
 - None
- What issues or concerns have we not asked about that you believe are important?
 - None
 - No
 - Believe that eventually, EMS services will need to be run by or at the county level. The local services are dwindling and will not be able to continue providing services.
 - None
 - None to report
 - Nothing new
 - Rural response area and times to respond to the region. Dynamics and population change when events (Groundhogs Day), summer camping, festivals, etc., occur.
 - None
 - None
- Is there anything else you want to share about EMS in your municipality?
 - None
 - The service has improved, but they want to go back to ALS and that will be too expensive. Borough is considering an ordinance on gaming machines to fund EMS.



- No
- Youth development education through the Department of Ed would be beneficial.
- No
- [We are] extremely happy with their EMS service. [She] related several stories about the excellence of the quality and caring of EMS in [the] township.
- Good collaboration and response efforts.
- No
- None to report
- Better employment opportunities in the area would encourage people to stay. We have the same problem with law enforcement. Both should be regionalized.
- The service wants to go back to ALS and that will be too expensive. Borough is considering an ordinance on gaming machines to fund EMS.

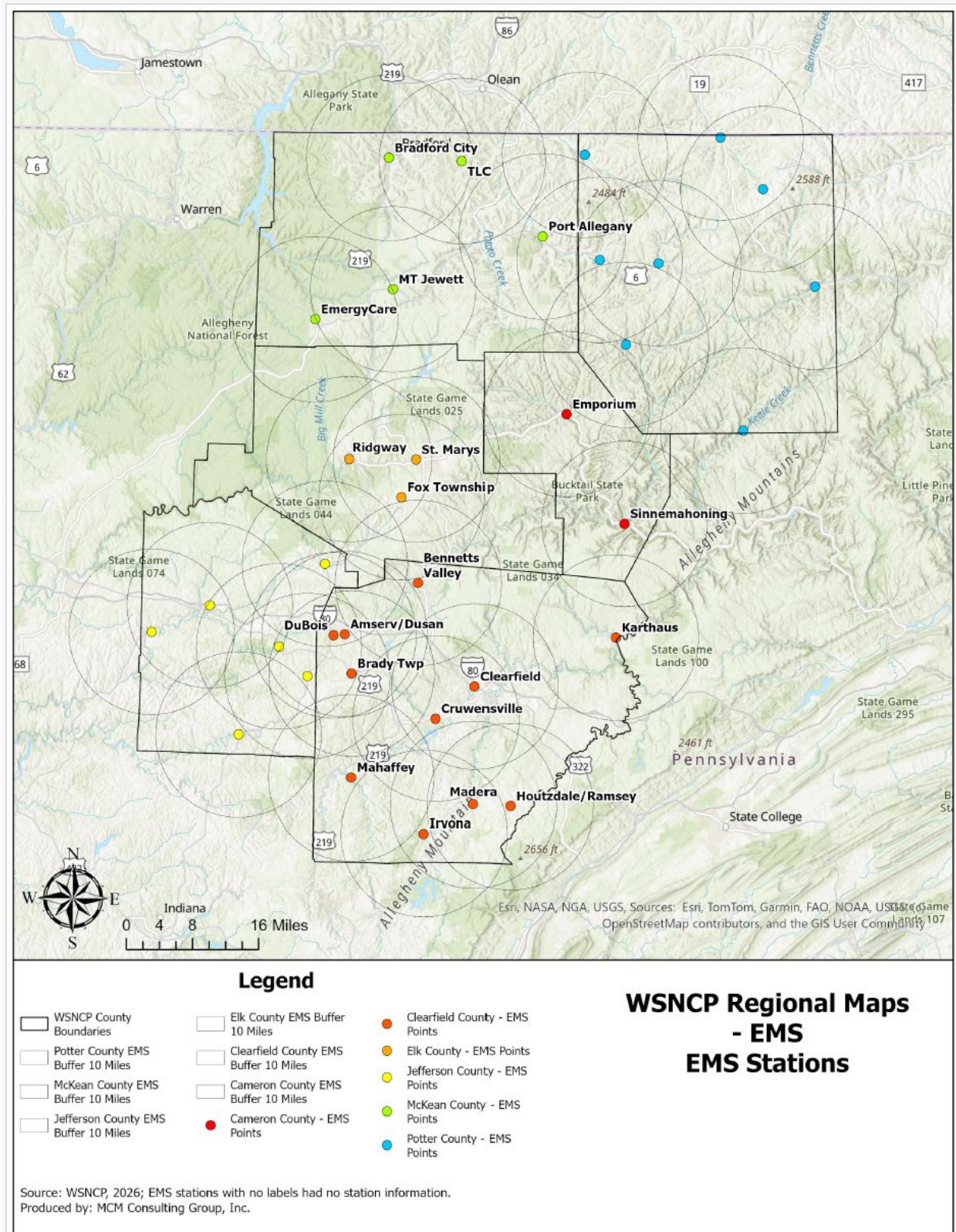


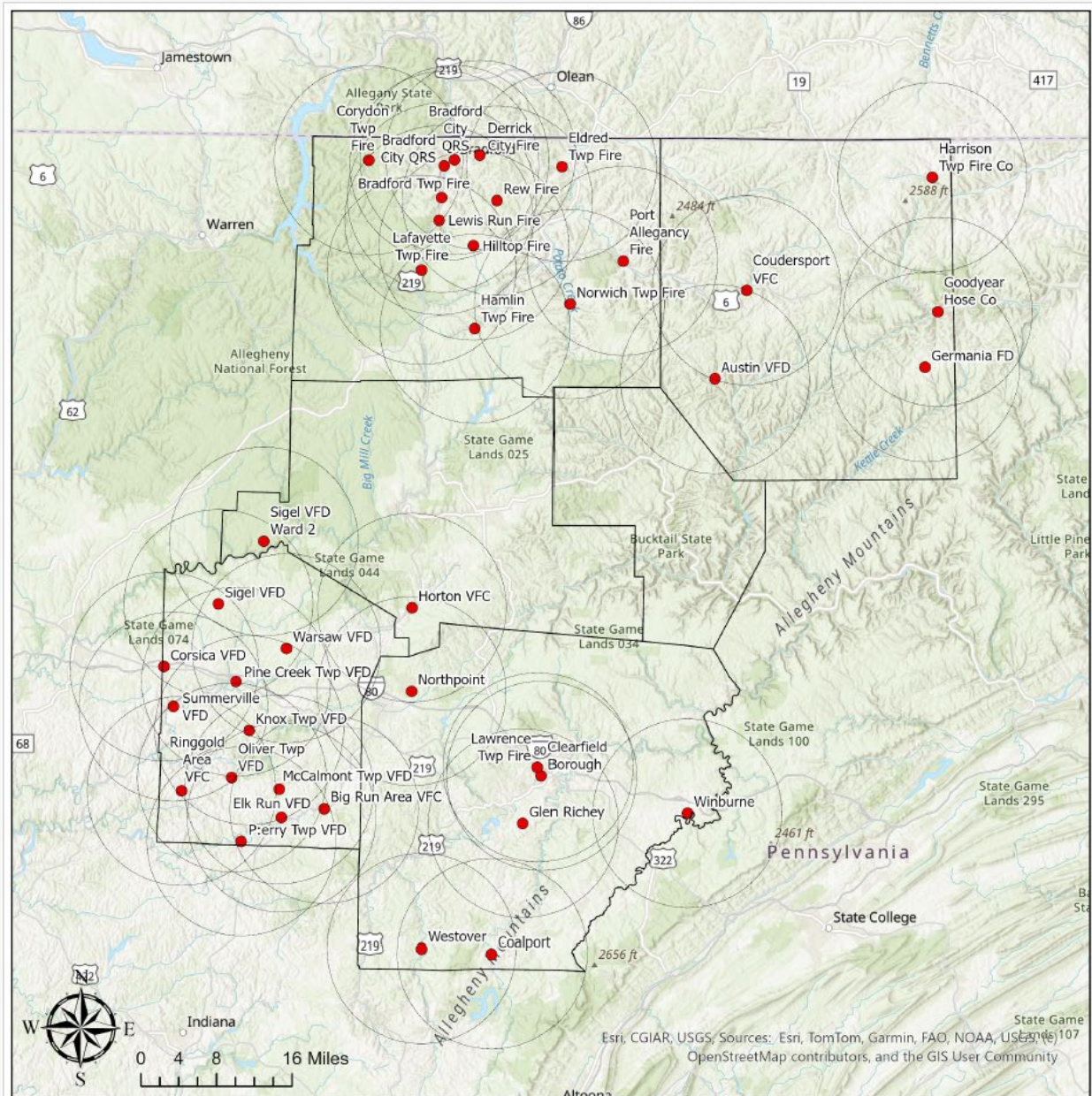
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Appendix D – EMS Response Maps



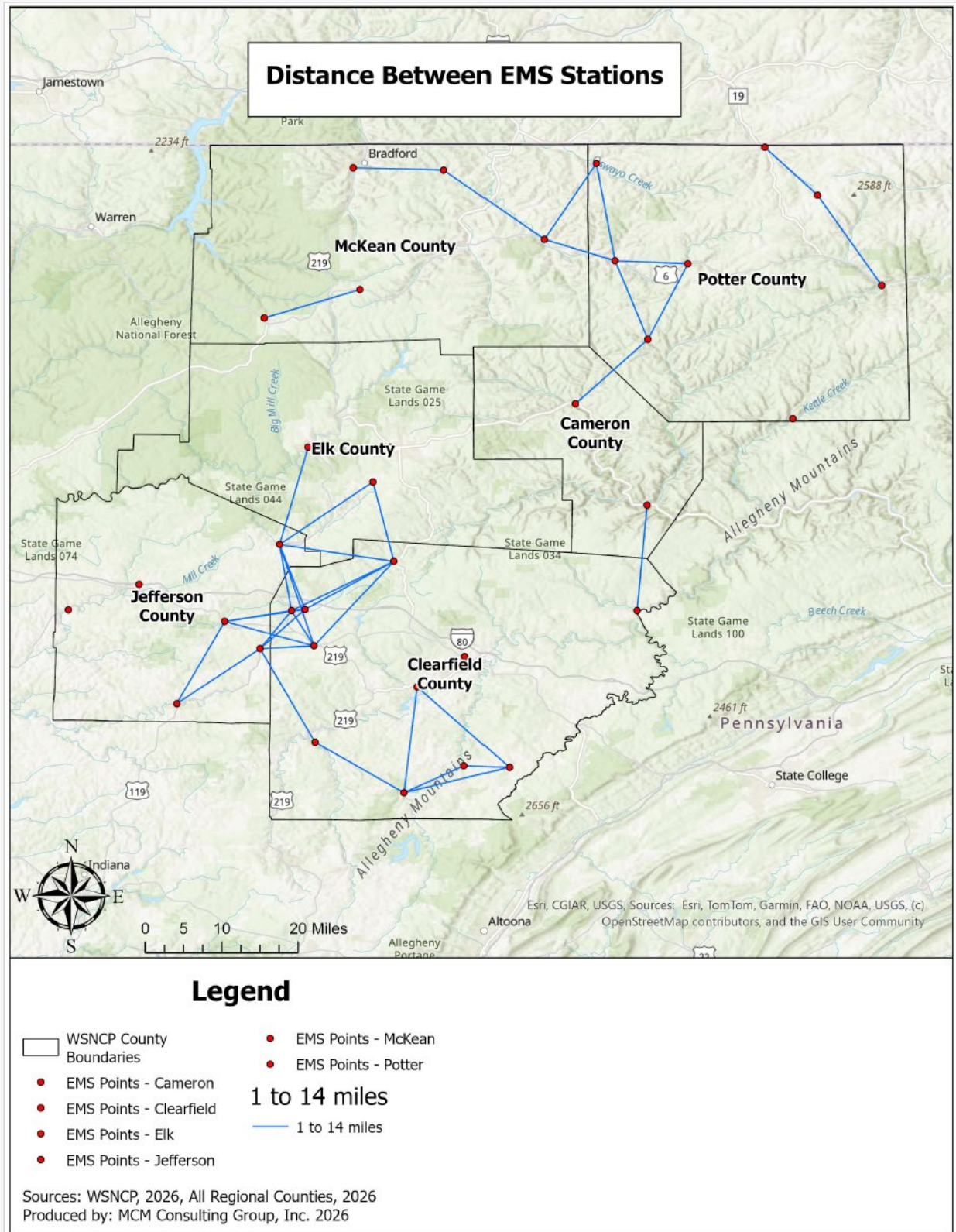


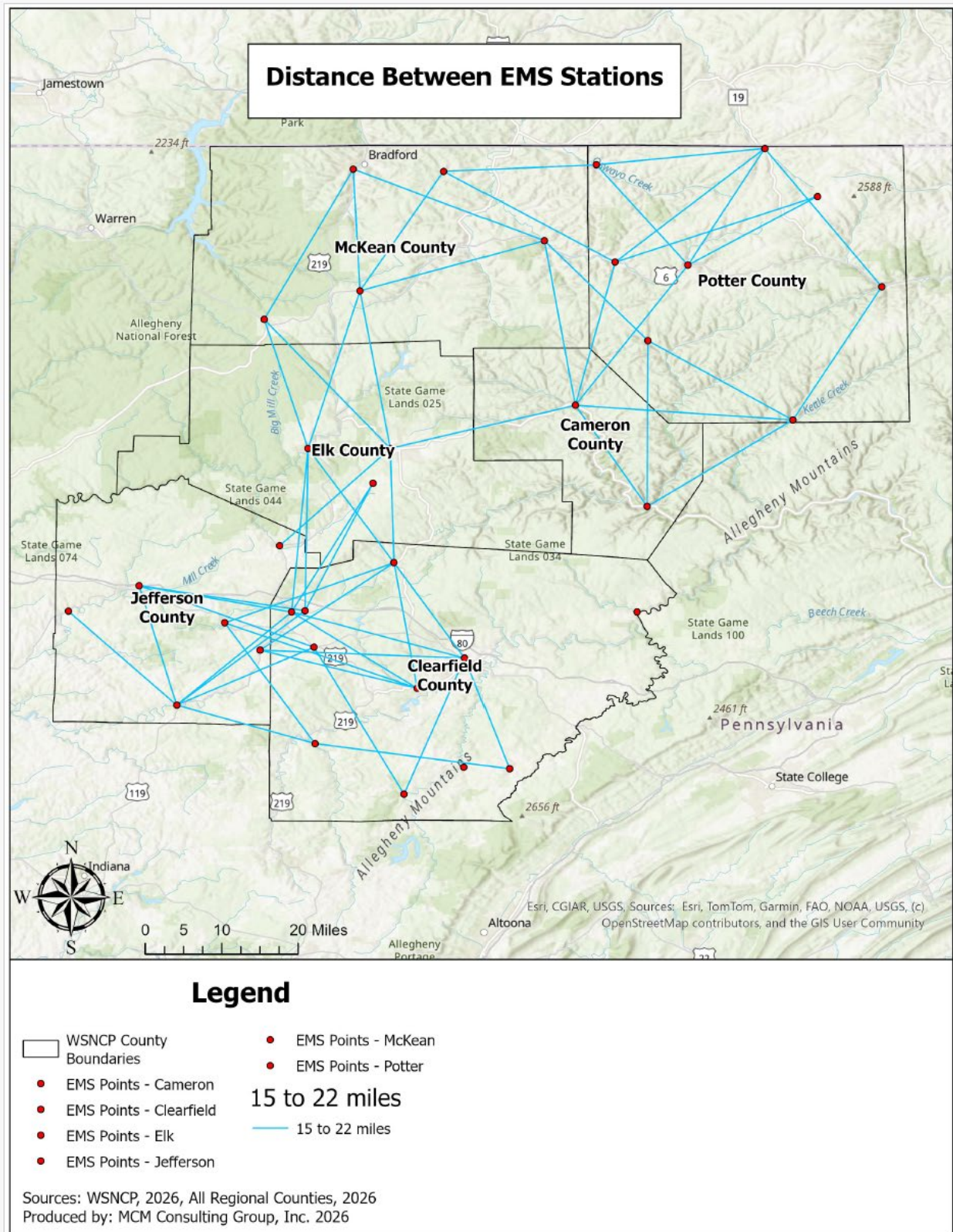
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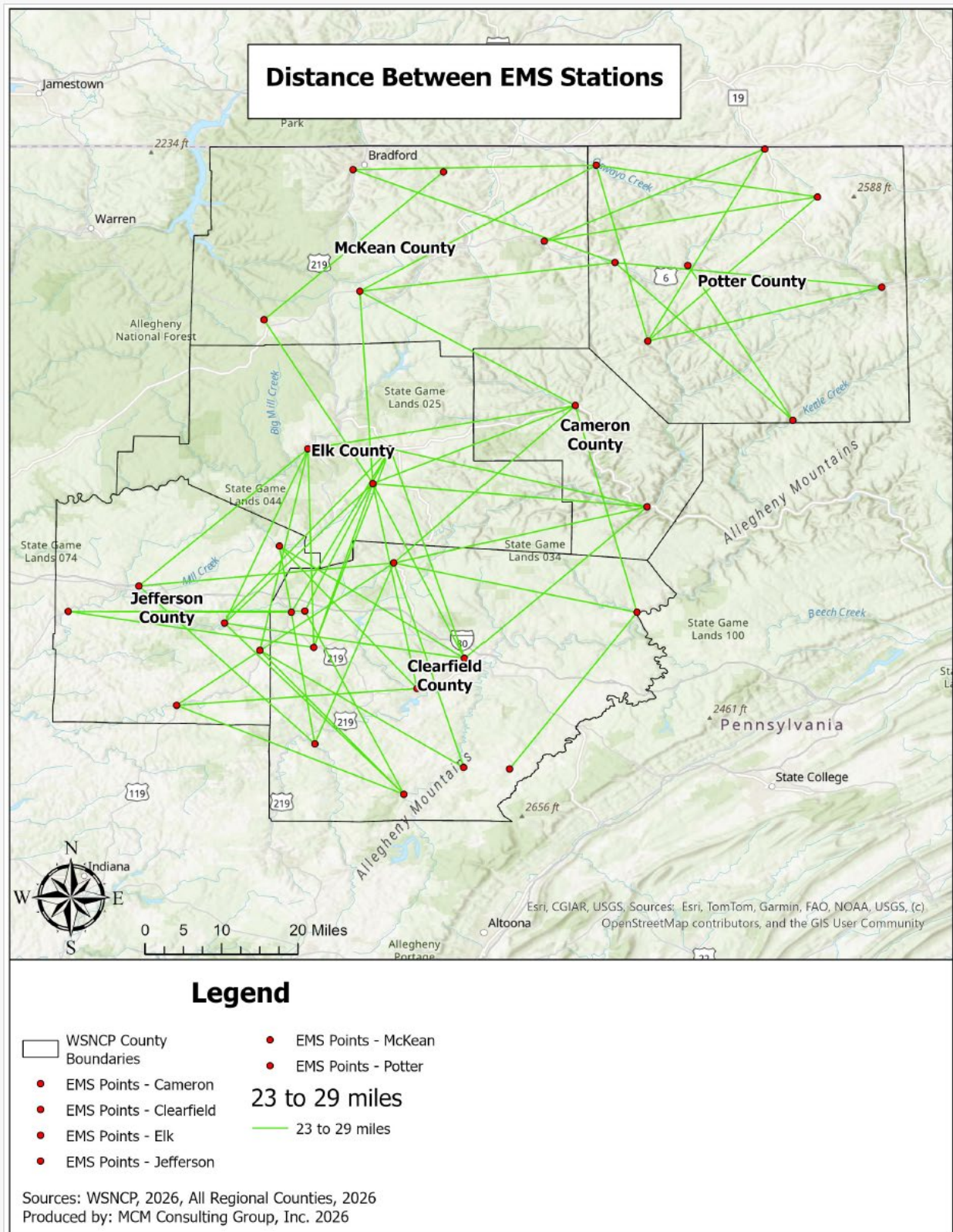
- | | | |
|---------------------------------------|-----------------------------------|-------------------------------|
| WSNCP County Boundaries | McKean County QRS Buffer 10 Miles | Jefferson County - QRS Points |
| Clearfield County QRS Buffer 10 Miles | Potter County QRS Buffer 10 Miles | McKean County - QRS Points |
| Elk County QRS Buffer 10 Miles | Clearfield County - QRS Points | Potter County - QRS Points |
| Jefferson County QRS Buffer 10 Miles | Elk County - QRS Points | |

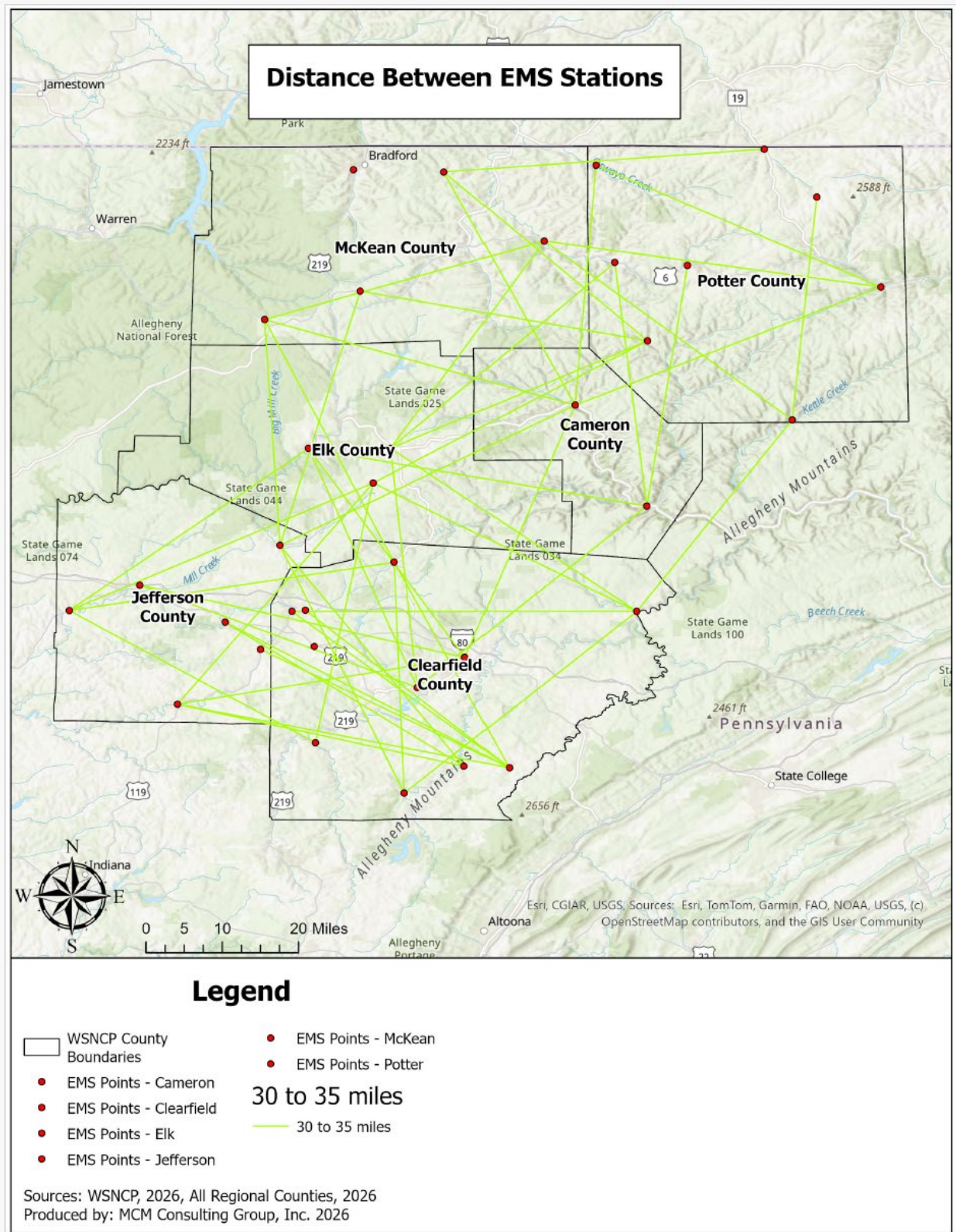
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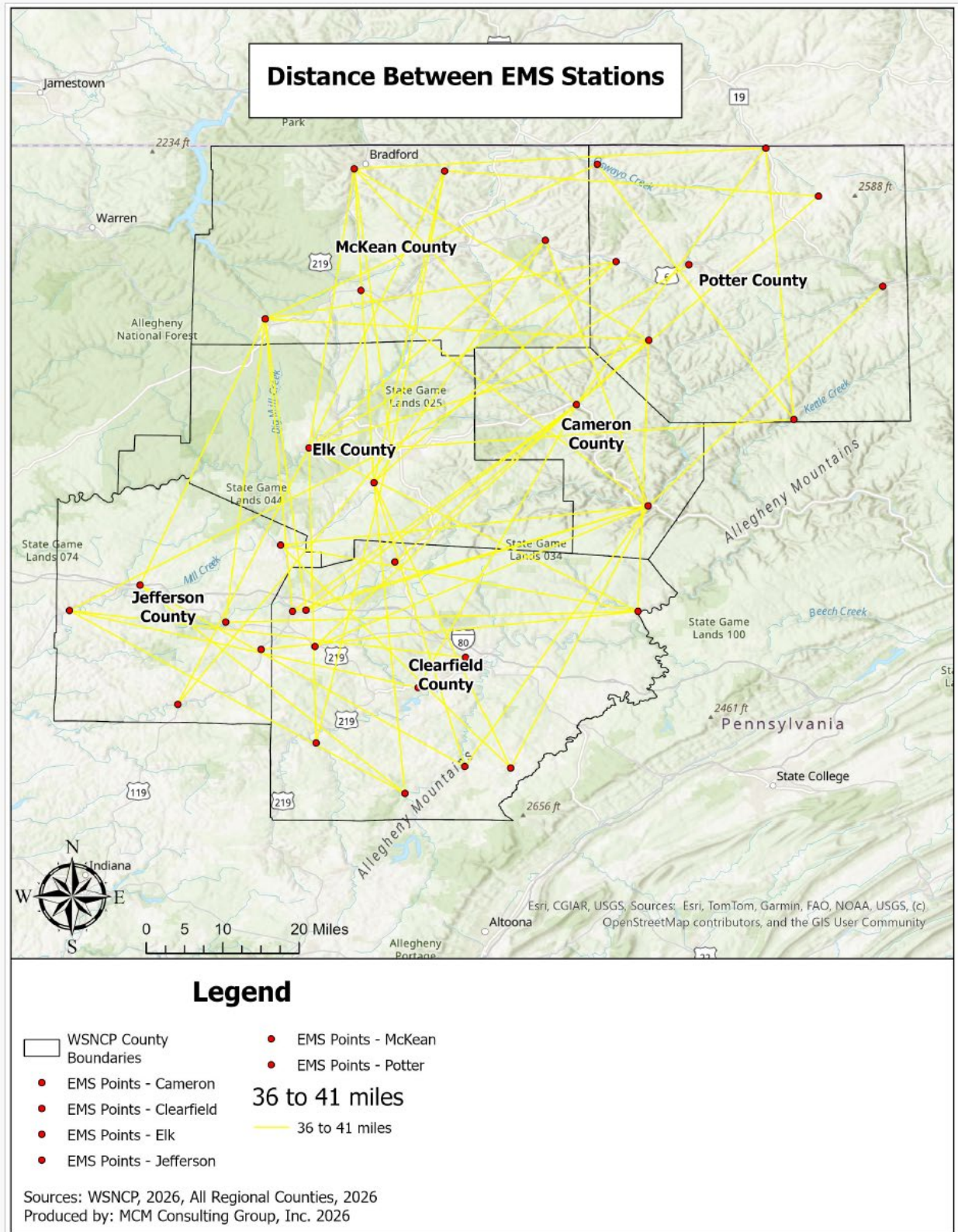
WSNCP Regional Maps - QRS QRS Stations

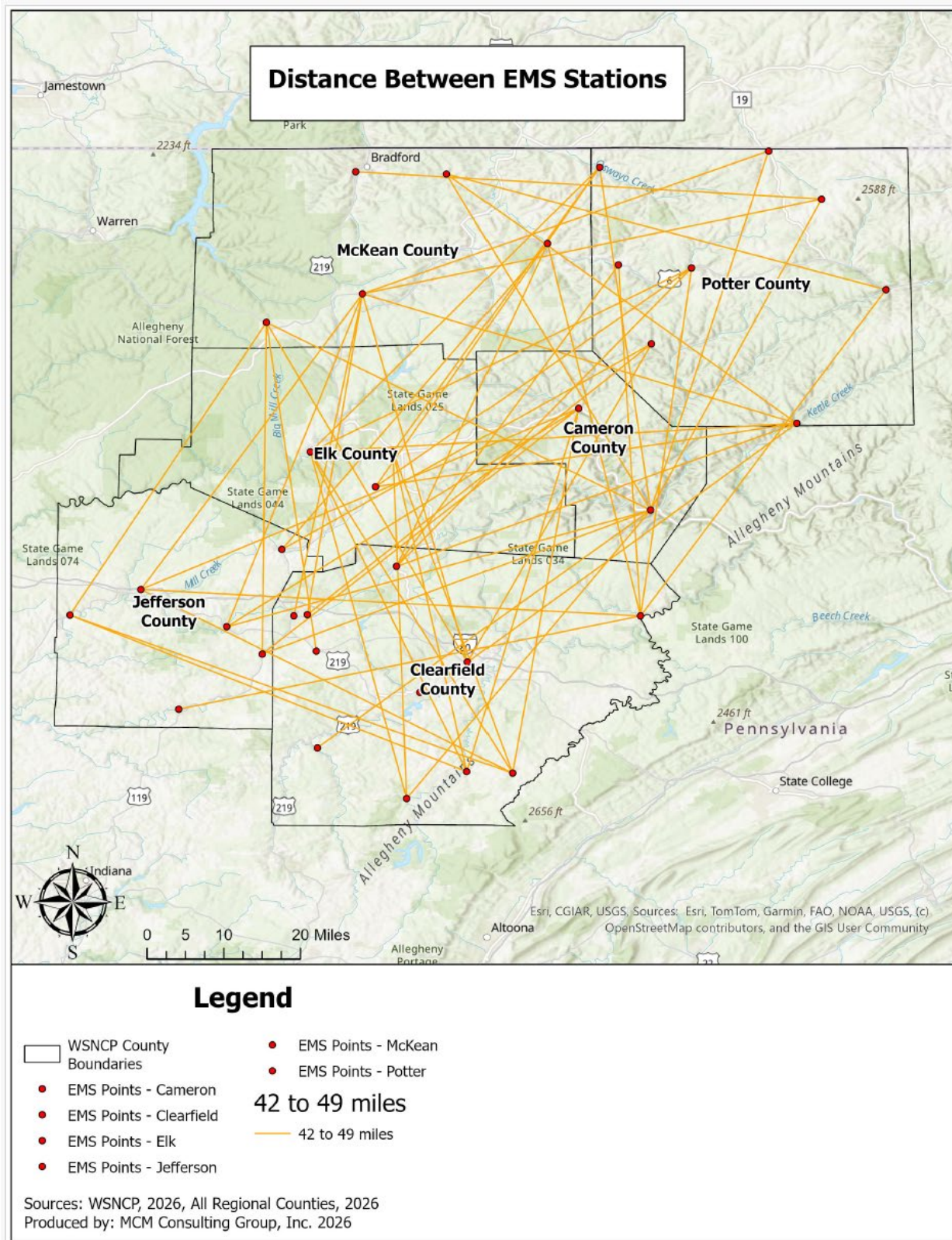


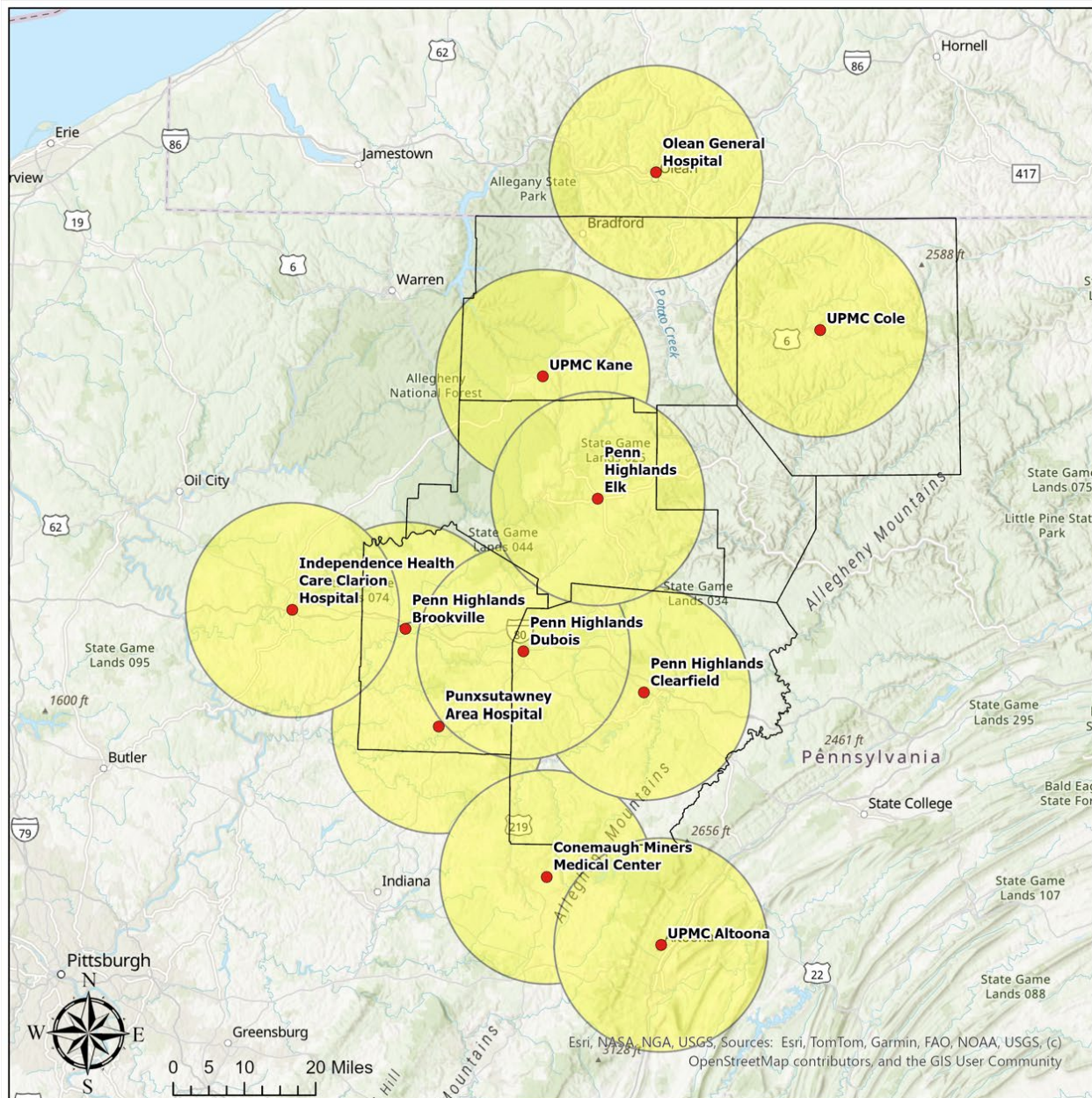










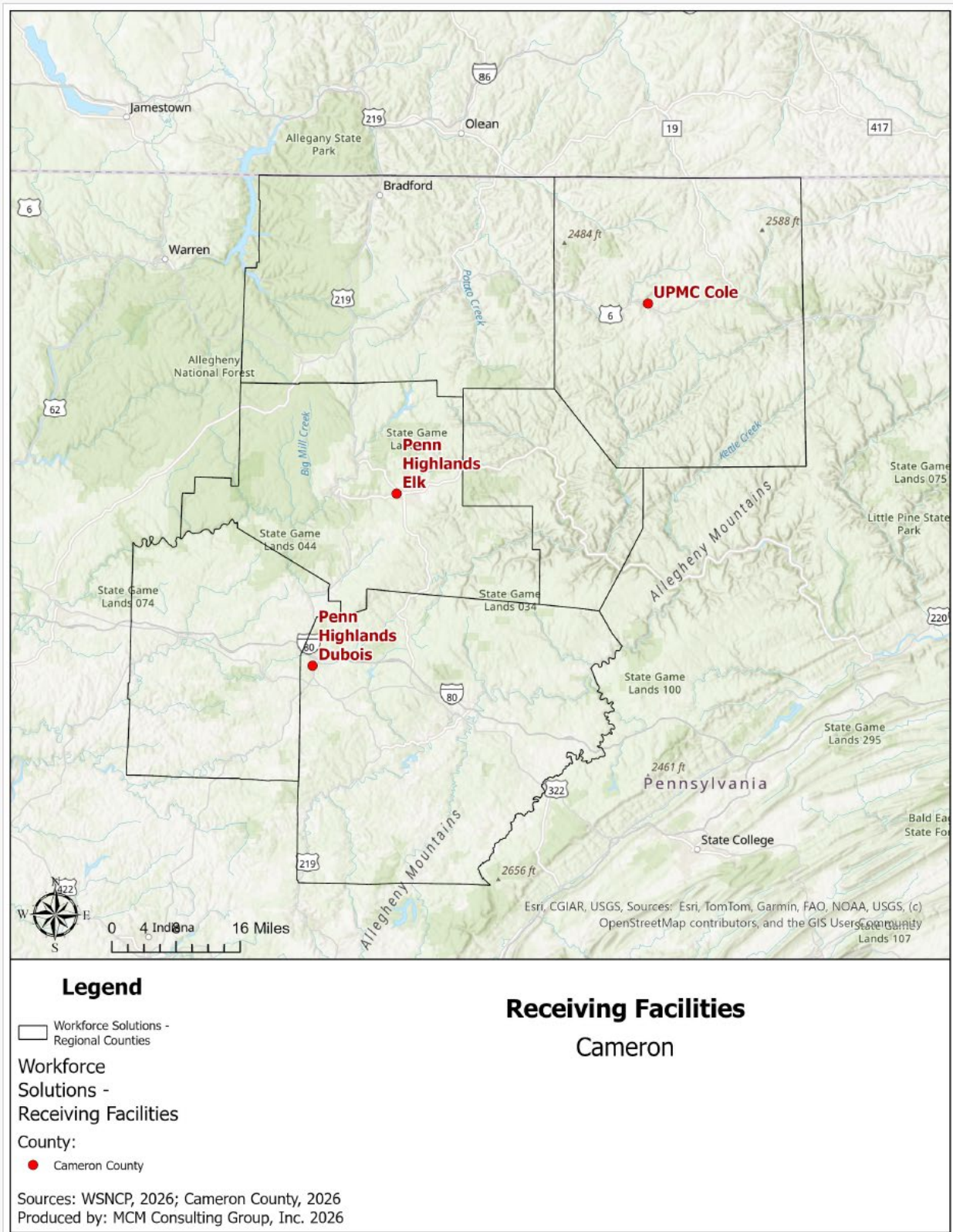


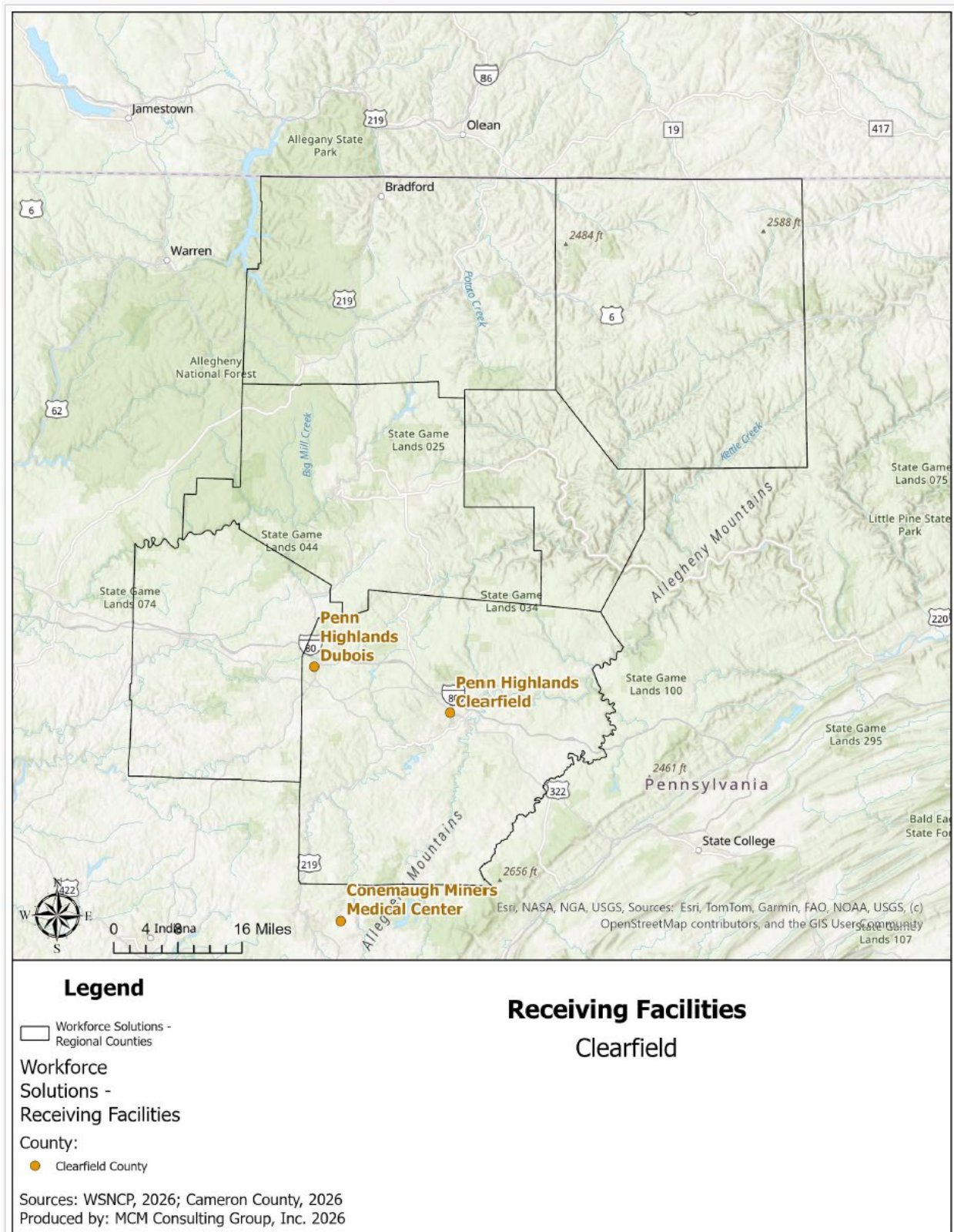
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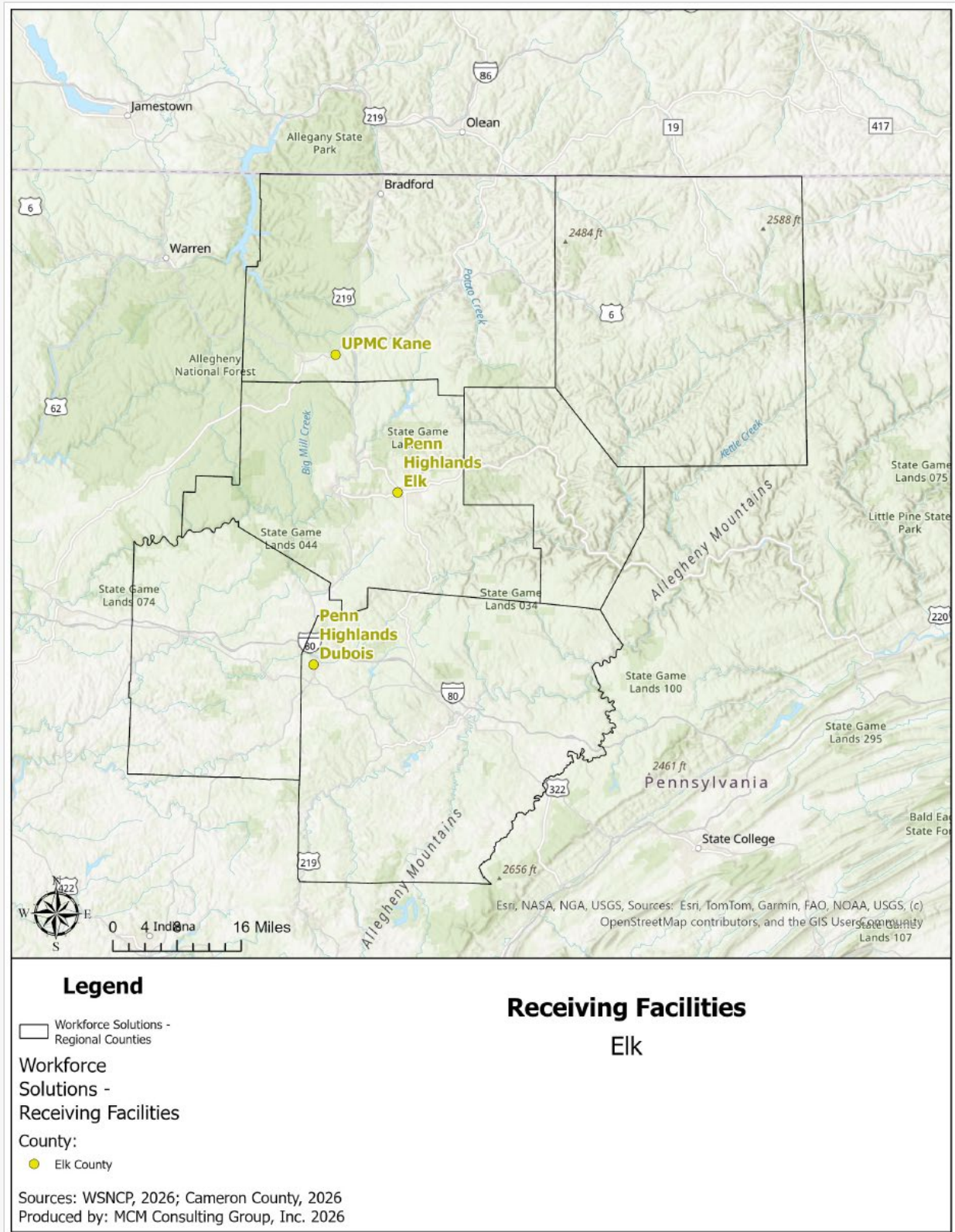
- Workforce Solutions - Receiving Facilities
- Workforce Solutions - Regional Counties
- Workforce Solutions - Receiving Facilities 15-mile Buffer

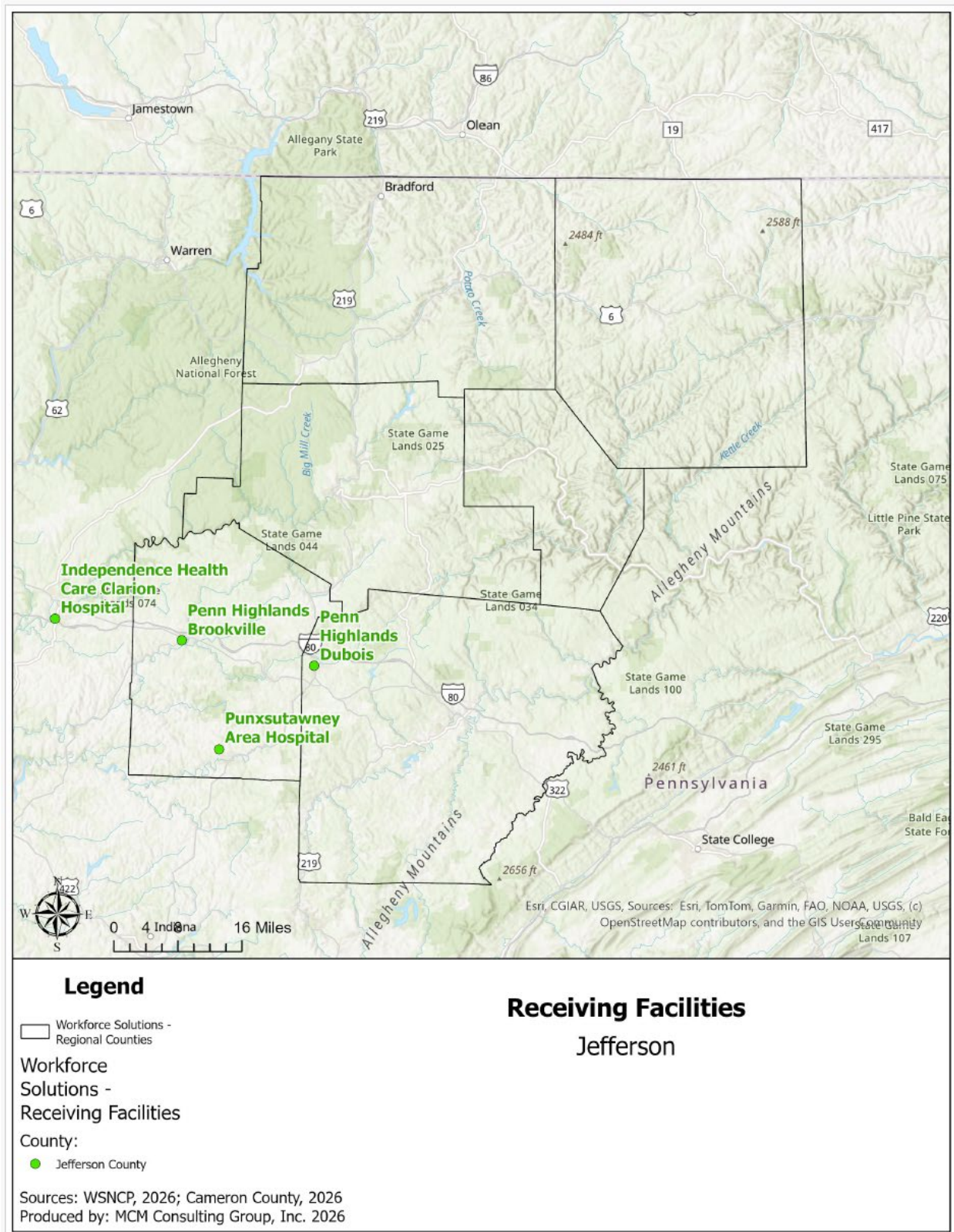
Sources: WSNCP, 2026
Produced by: MCM Consulting Group, Inc. 2026

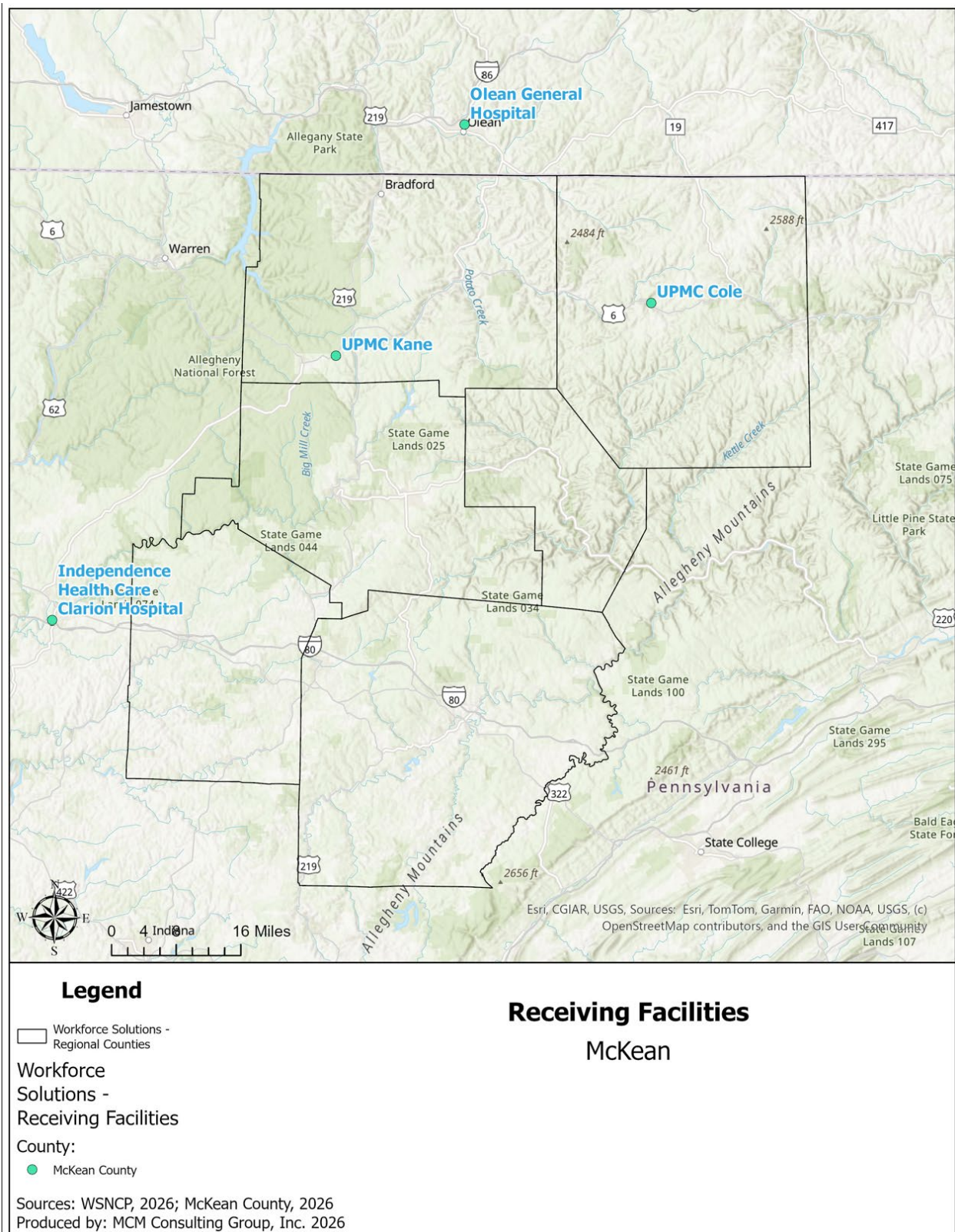
Overall Receiving Facilities - Workforce Solutions

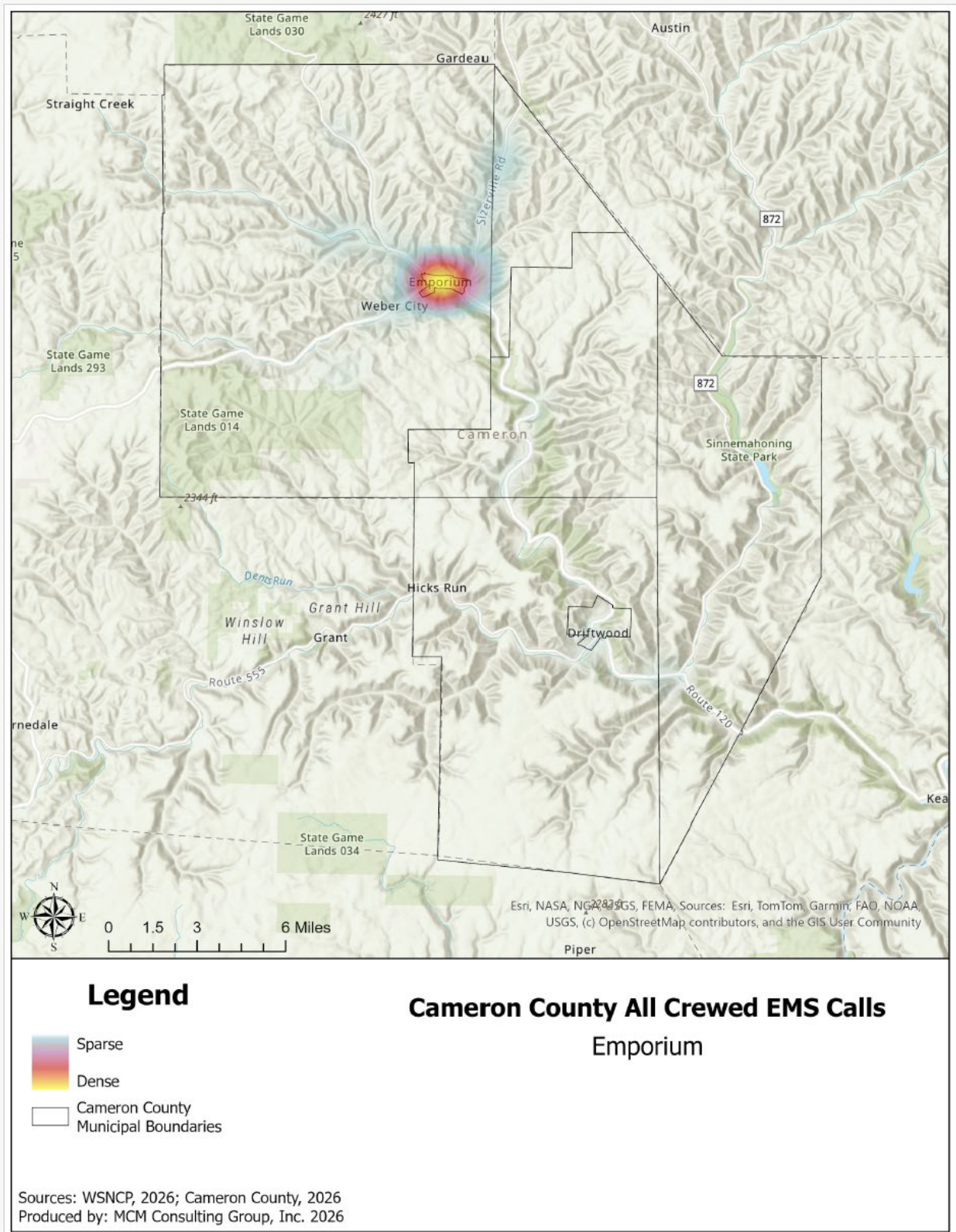


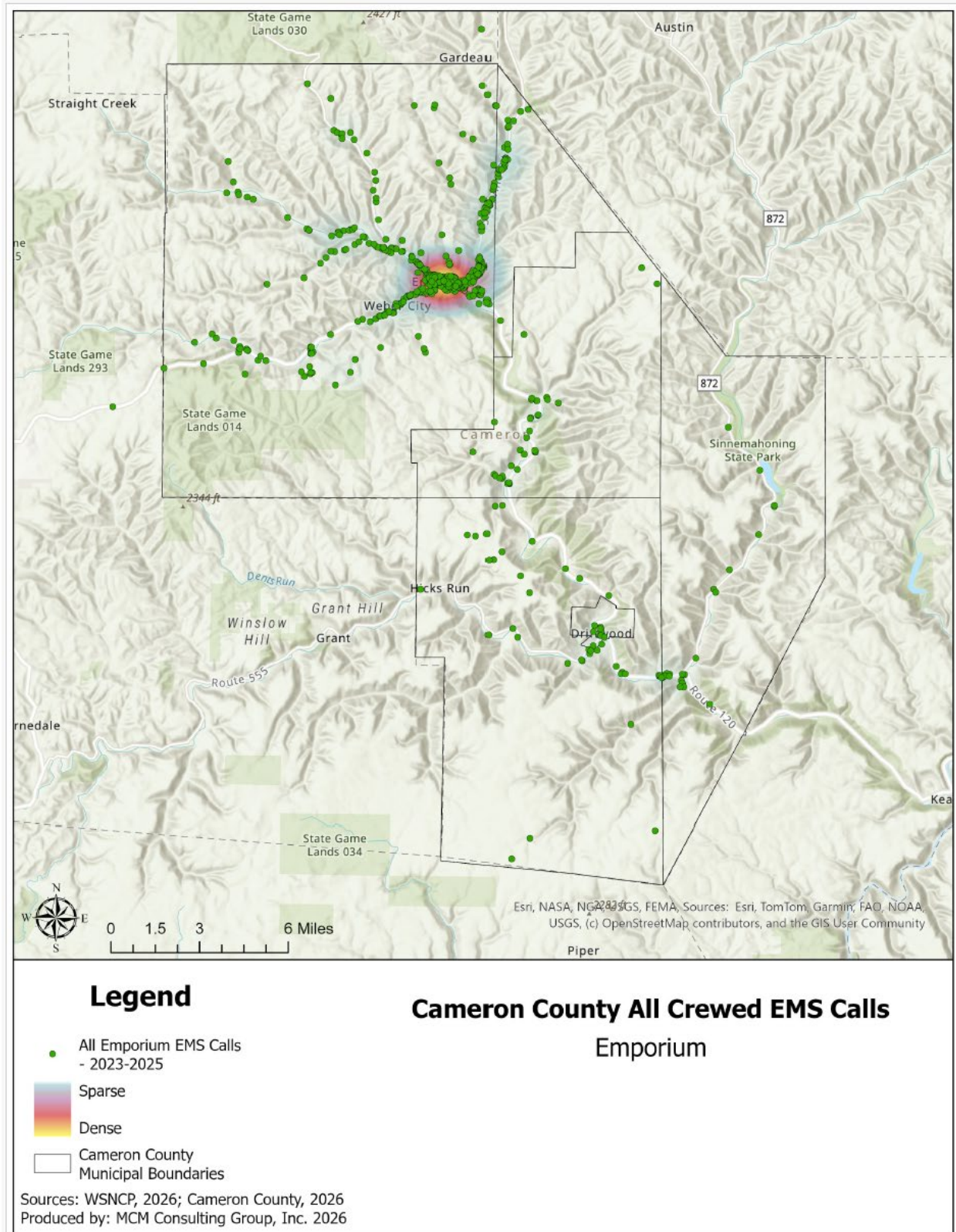


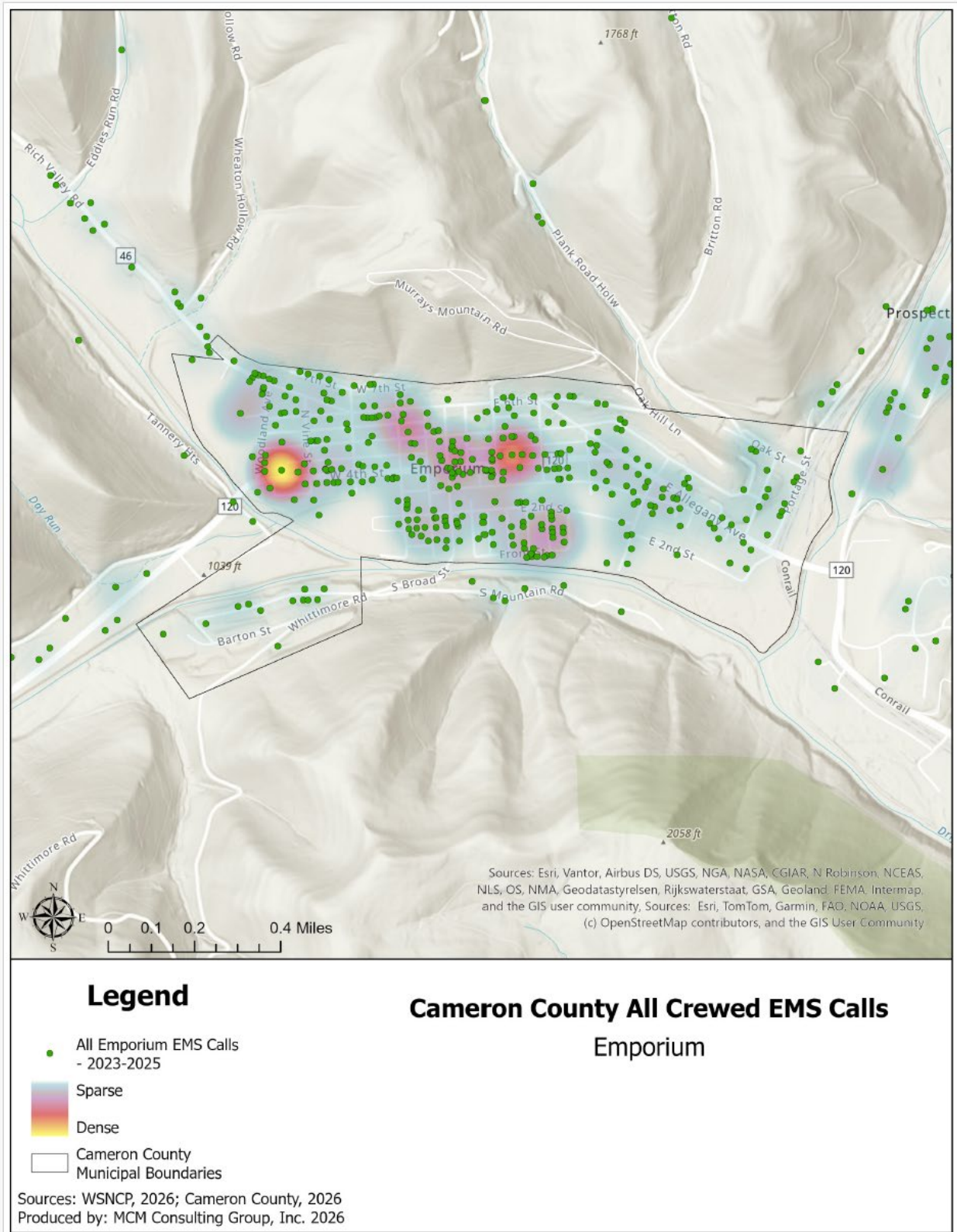


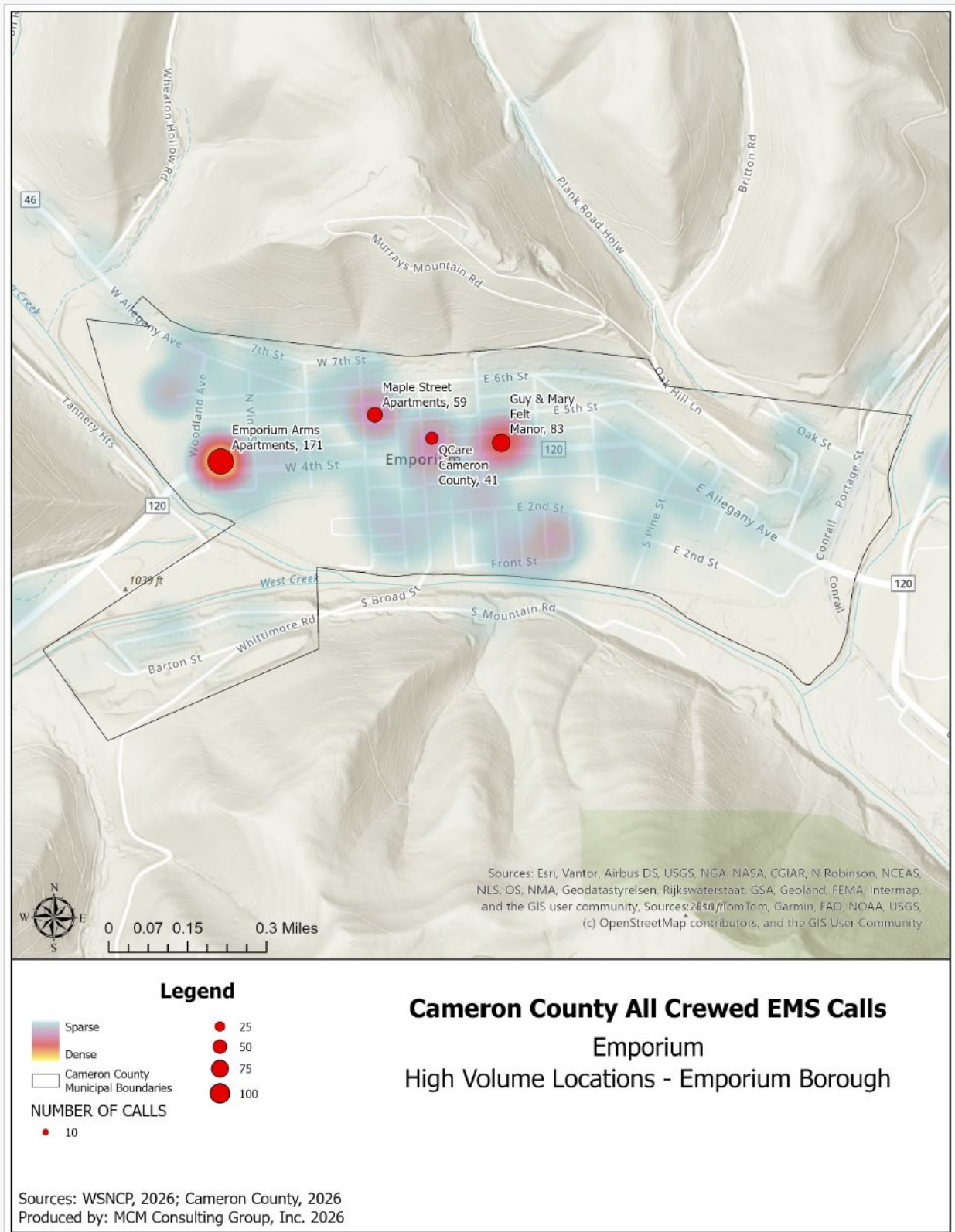


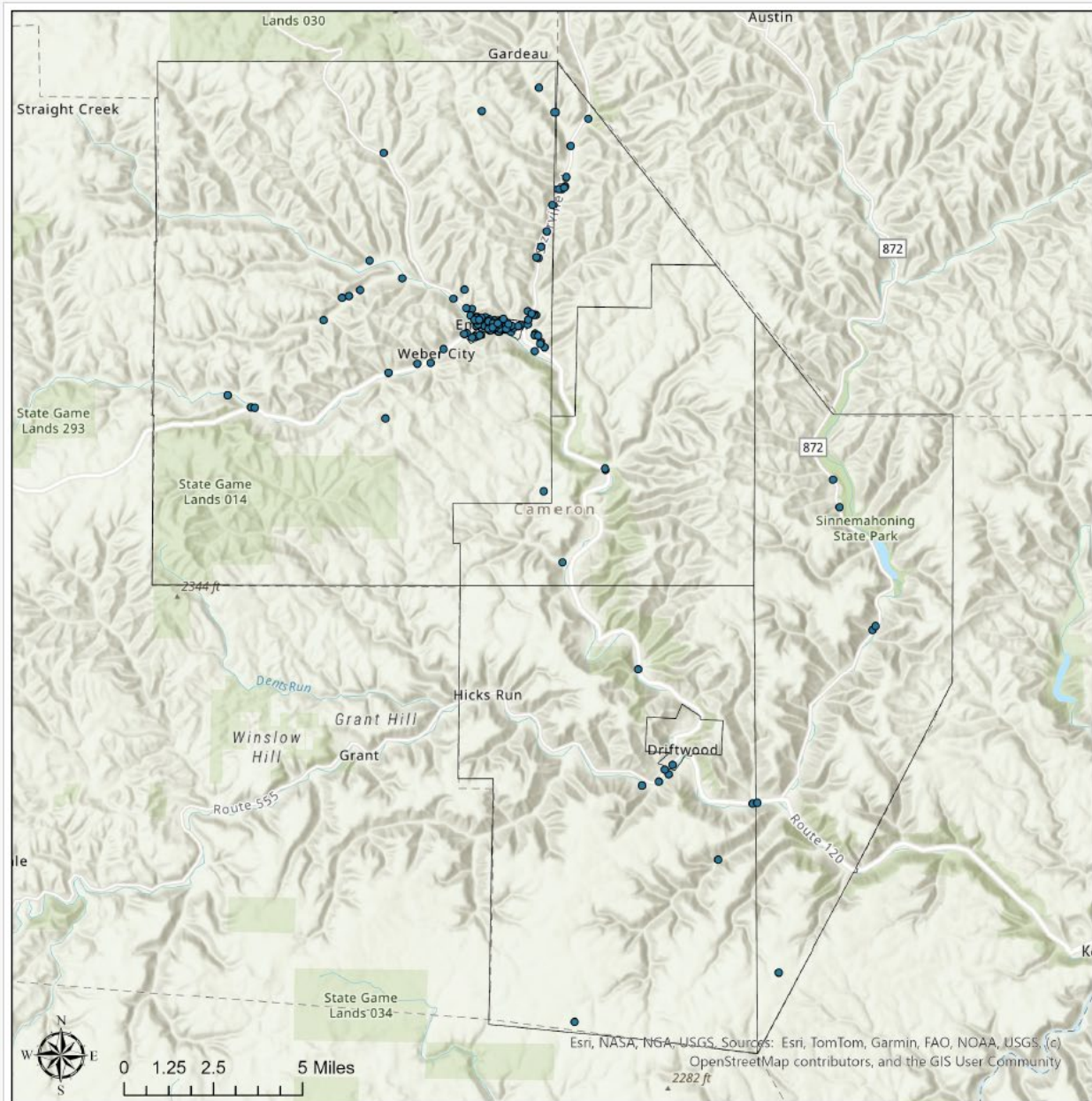










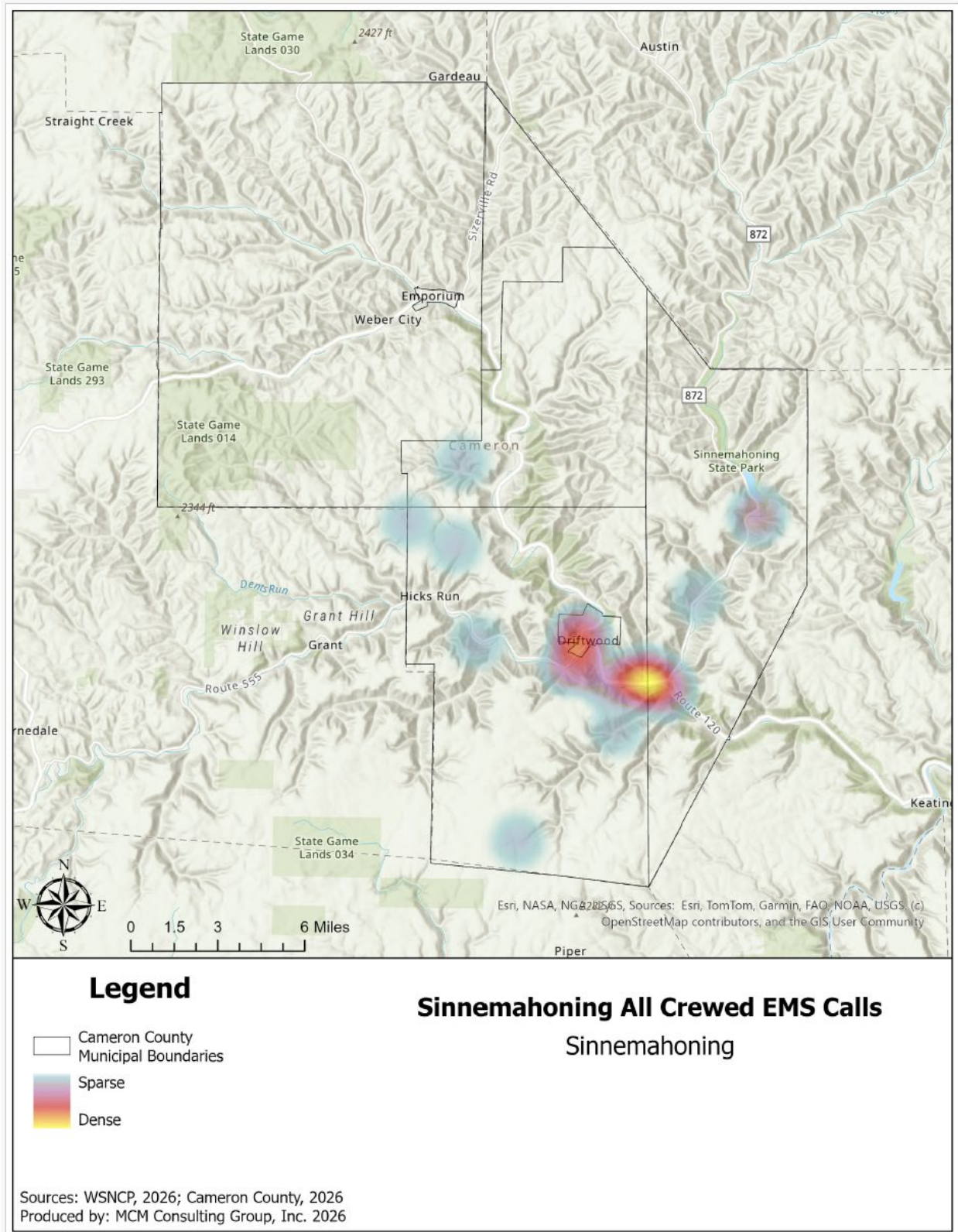


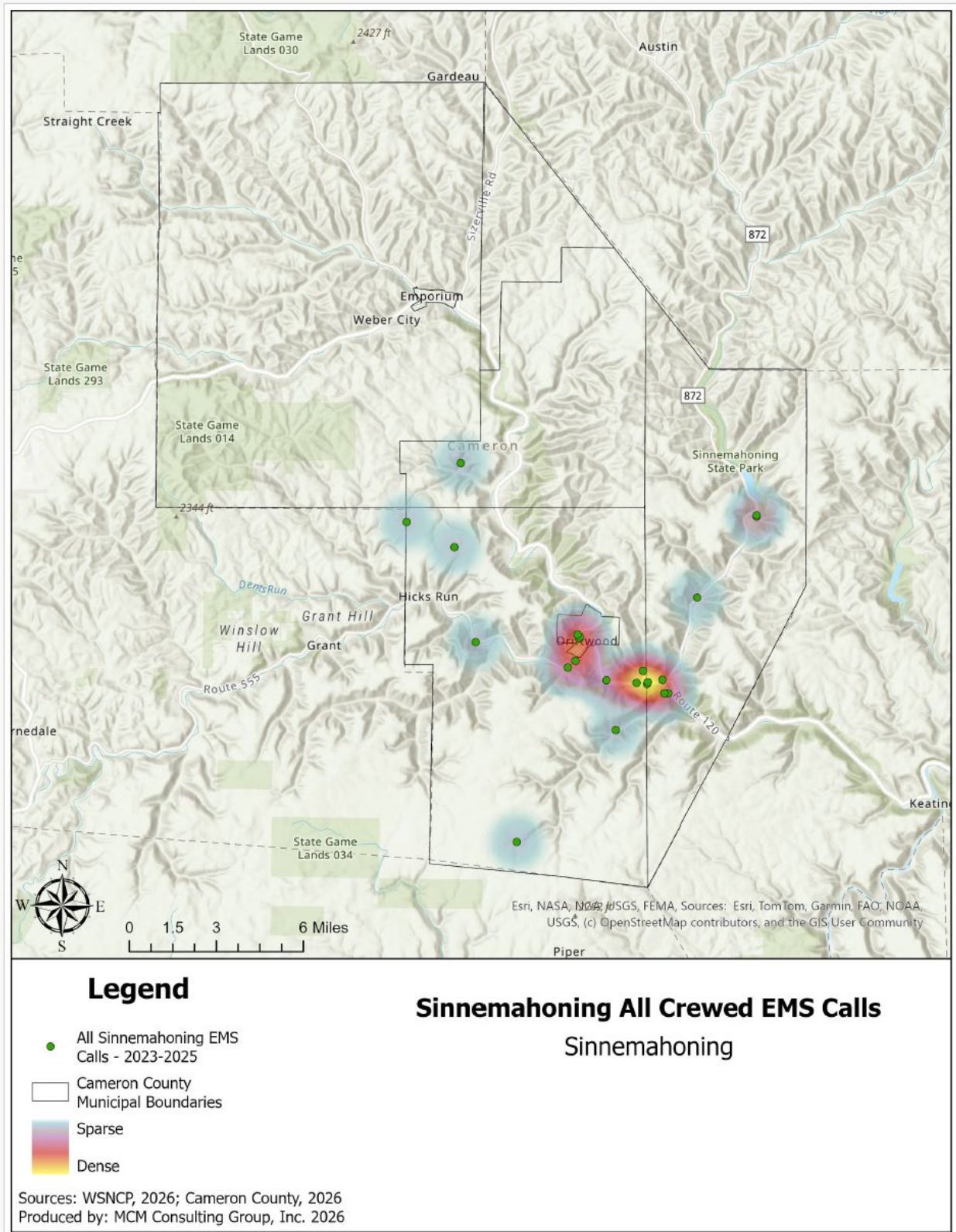
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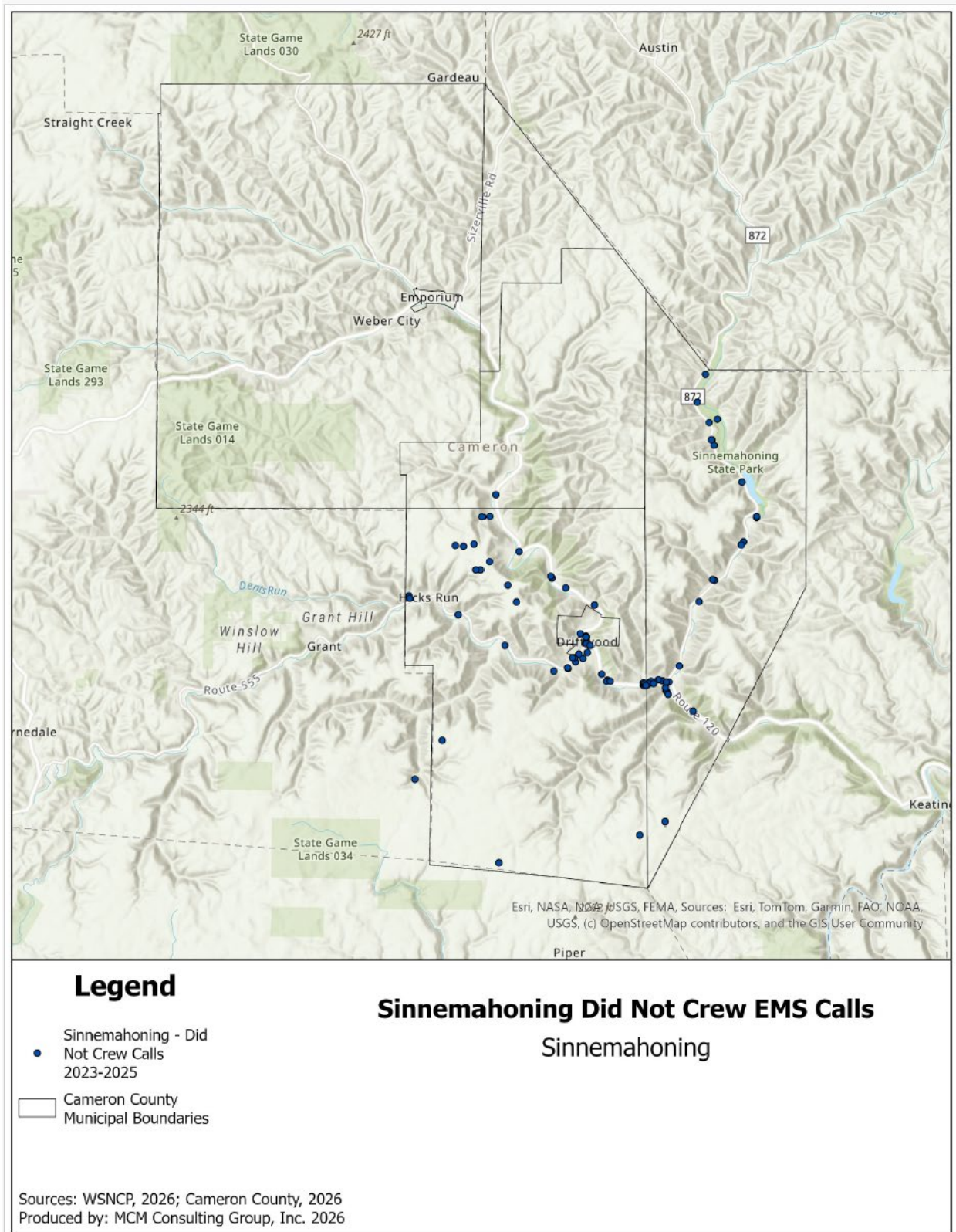
- Emporium - Did Not Crew Calls 2023-2025
- ▭ Cameron County Municipal Boundaries

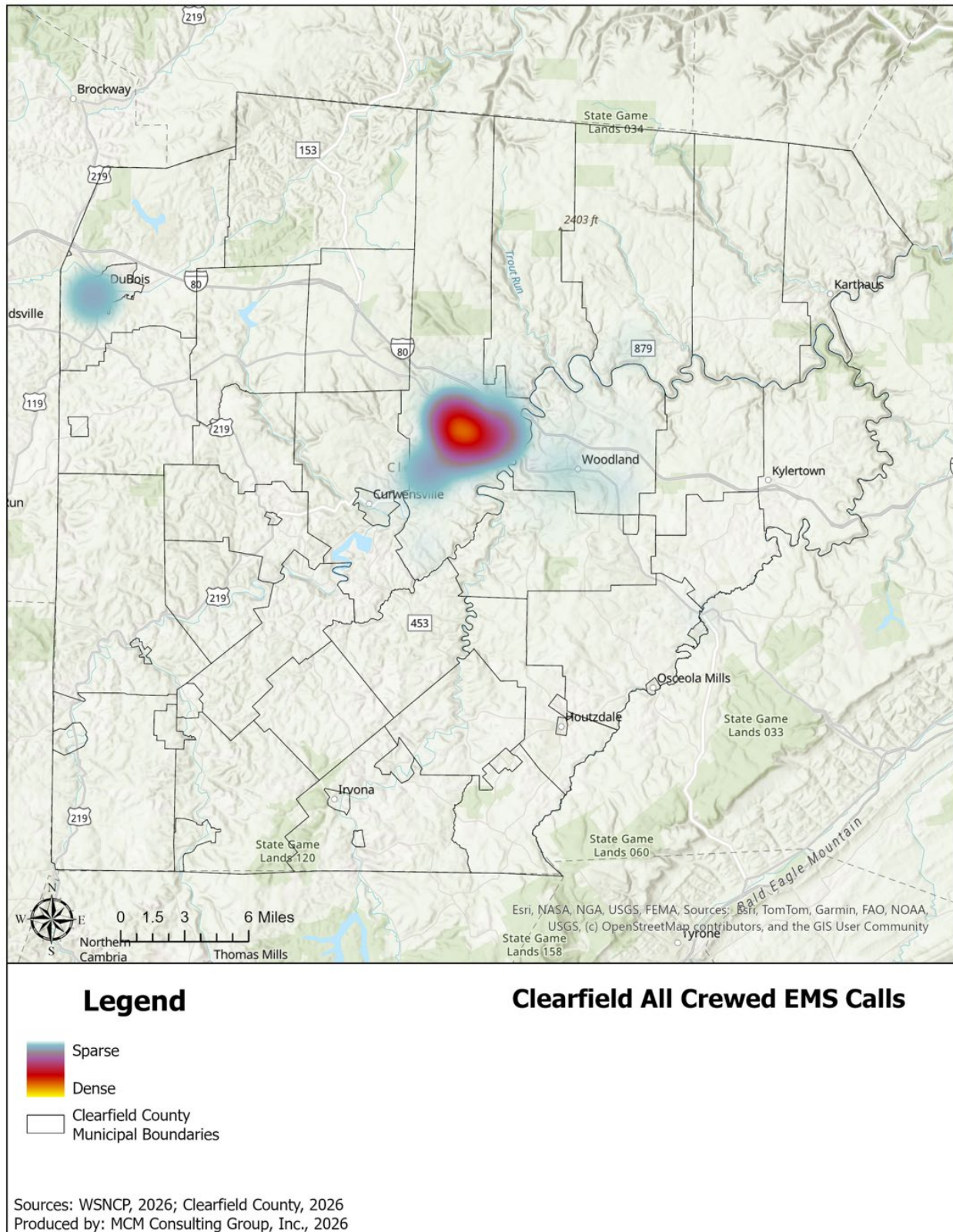
Cameron County Did Not Crew EMS Calls Emporium

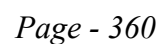
Sources: WSNCP, 2026; Cameron County, 2026
Produced by: MCM Consulting Group, Inc. 2026

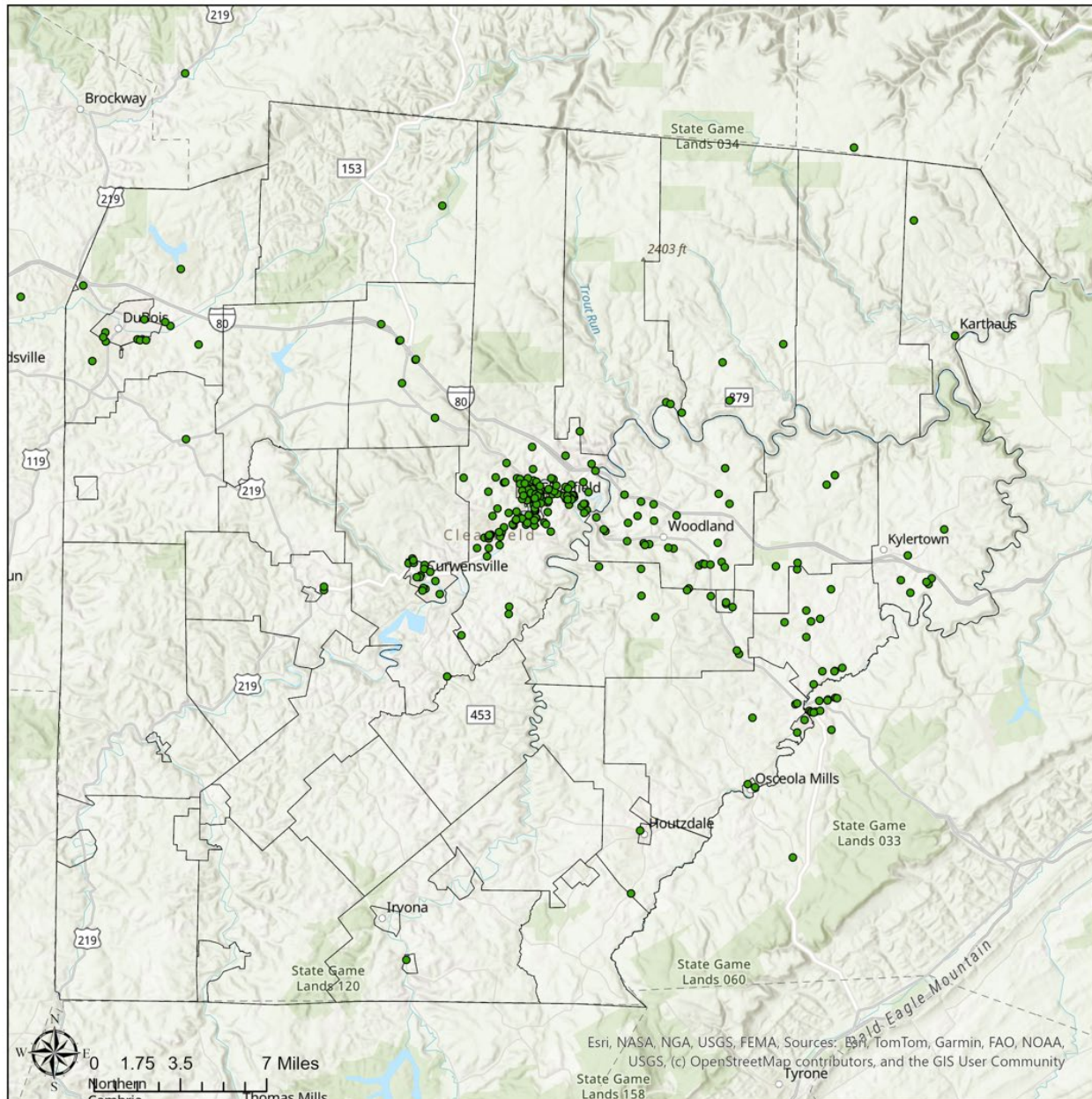










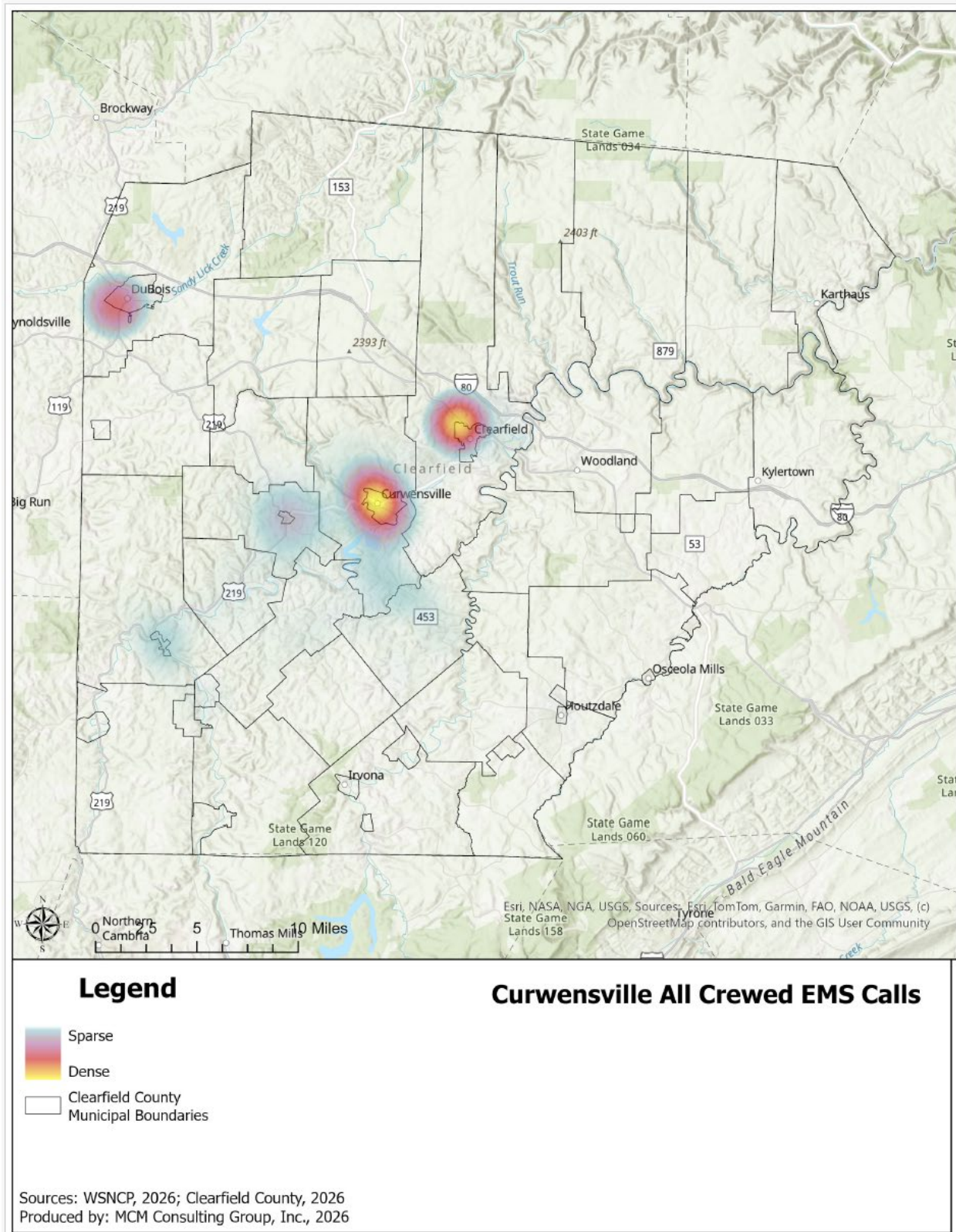


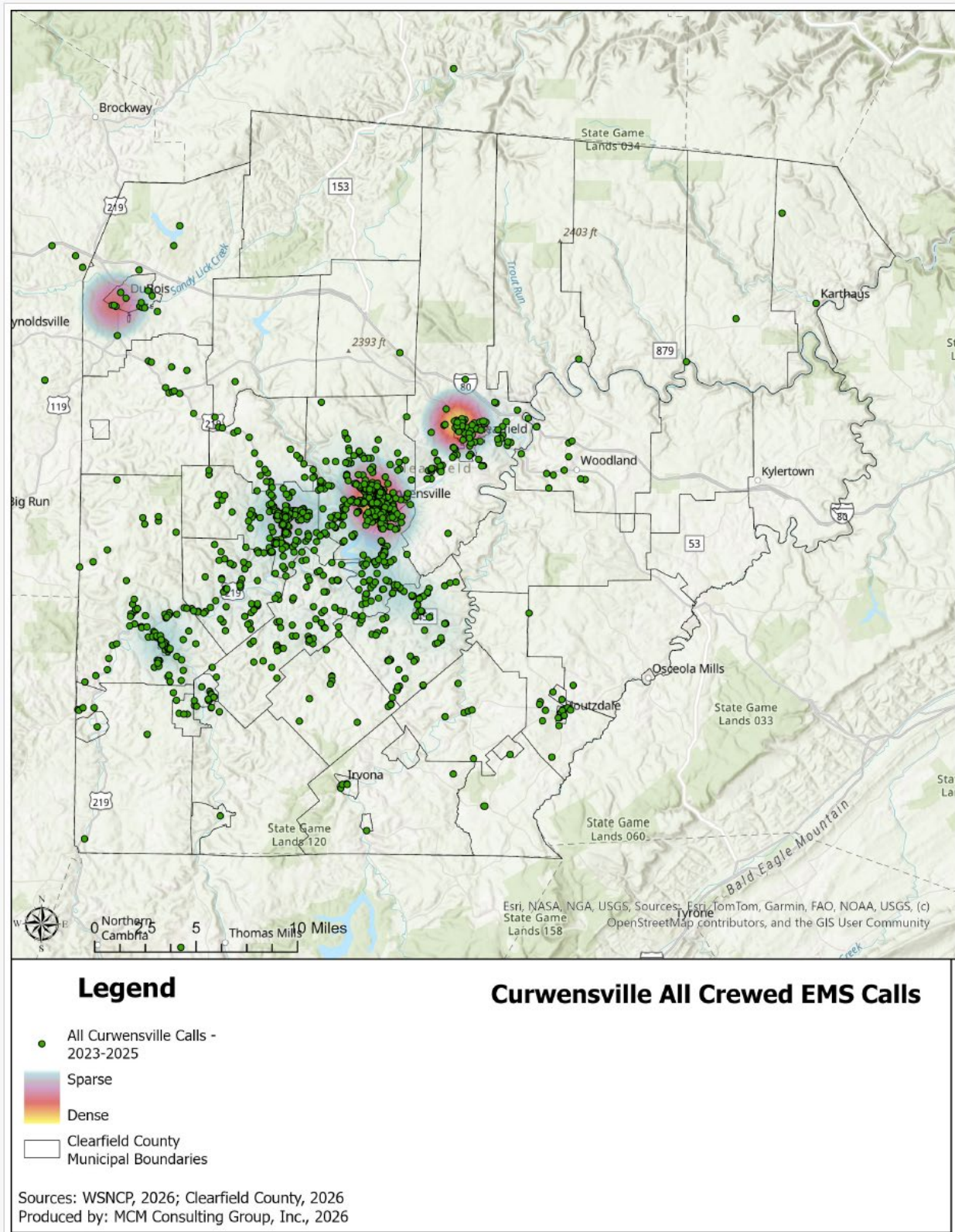
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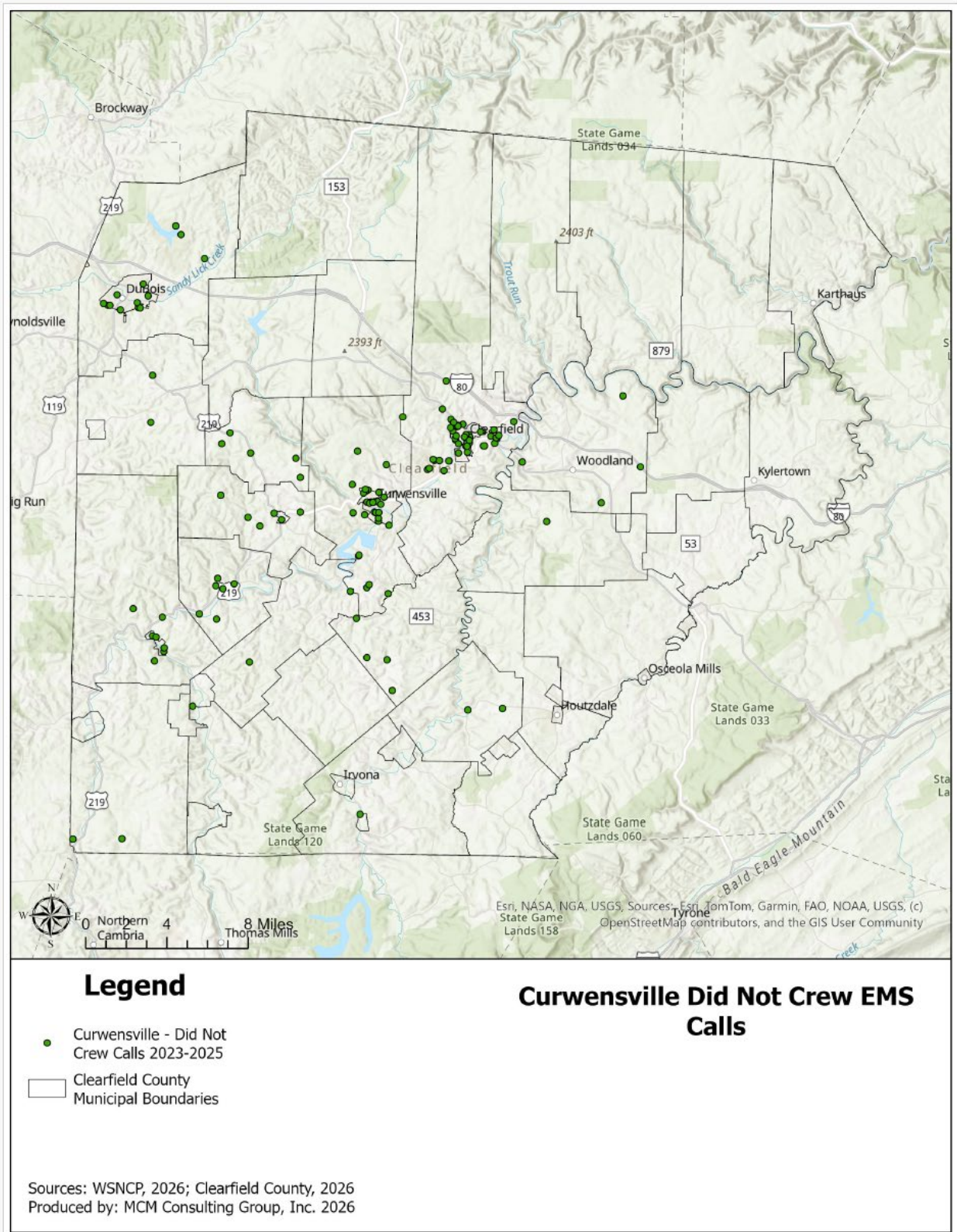
- Clearfield - Did Not Crew 2023-2025
- Clearfield County Municipal Boundaries

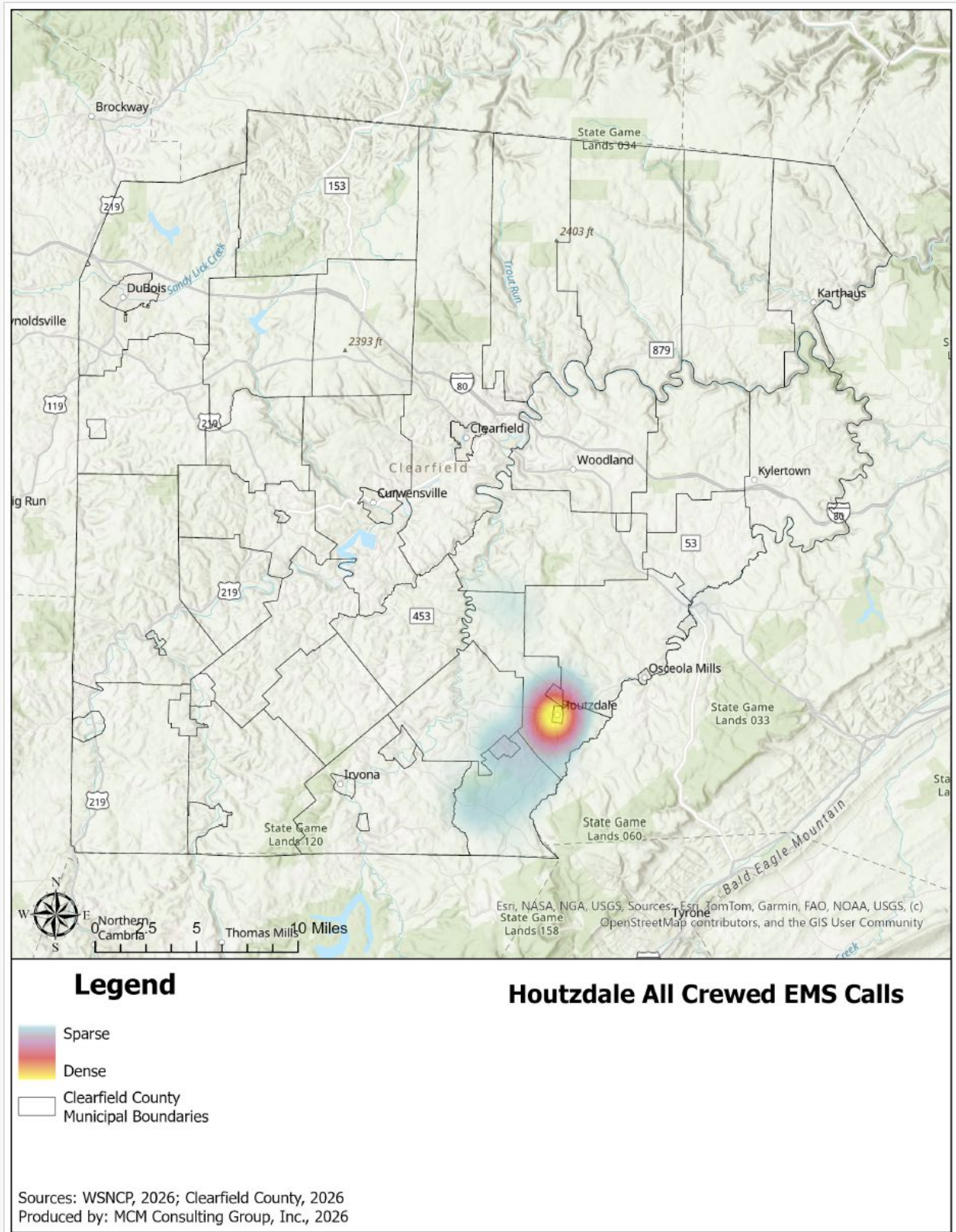
Clearfield Did Not Crew EMS Calls

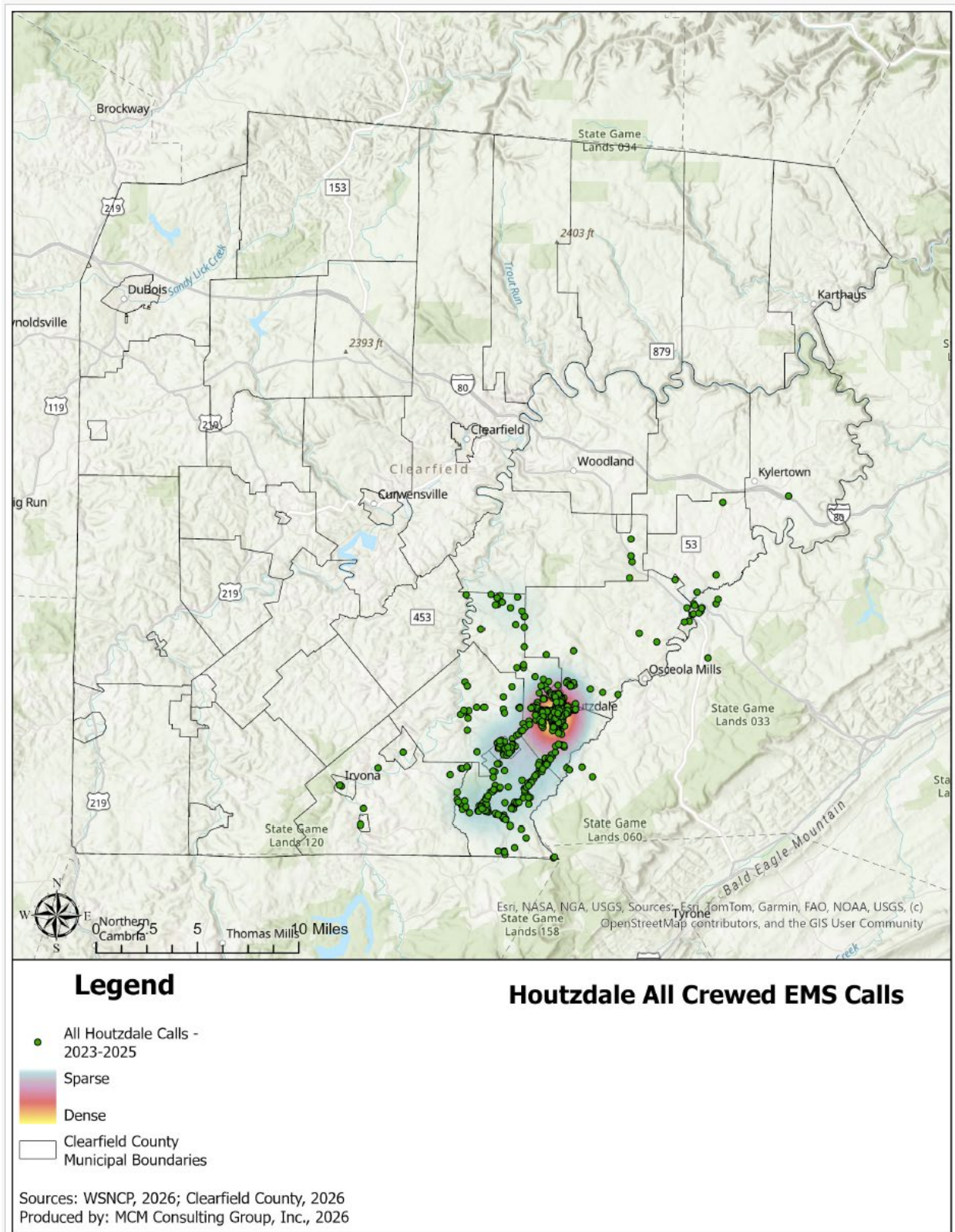
Sources: WSNCP, 2026; Clearfield County, 2026
Produced by: MCM Consulting Group, Inc. 2026

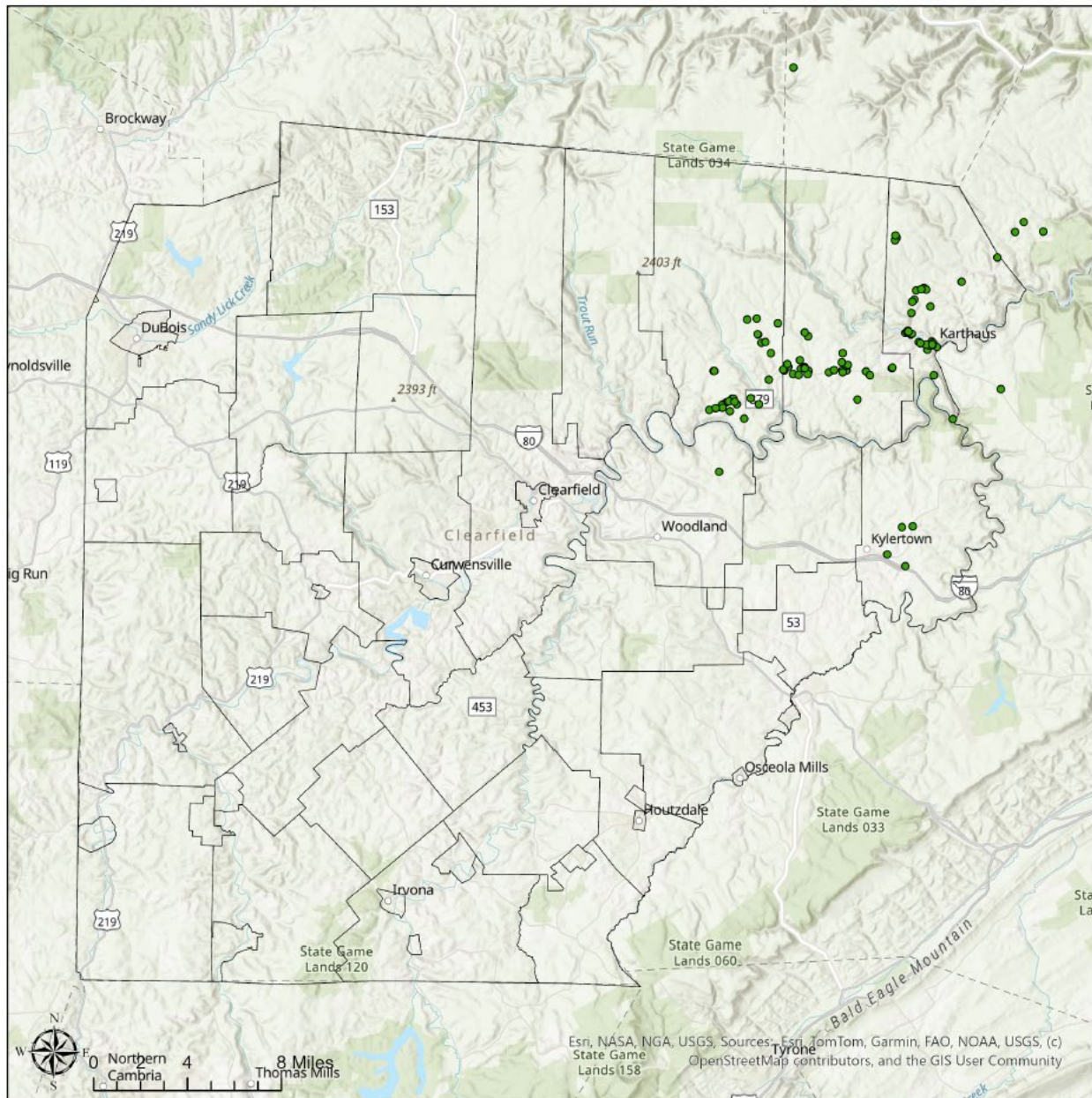










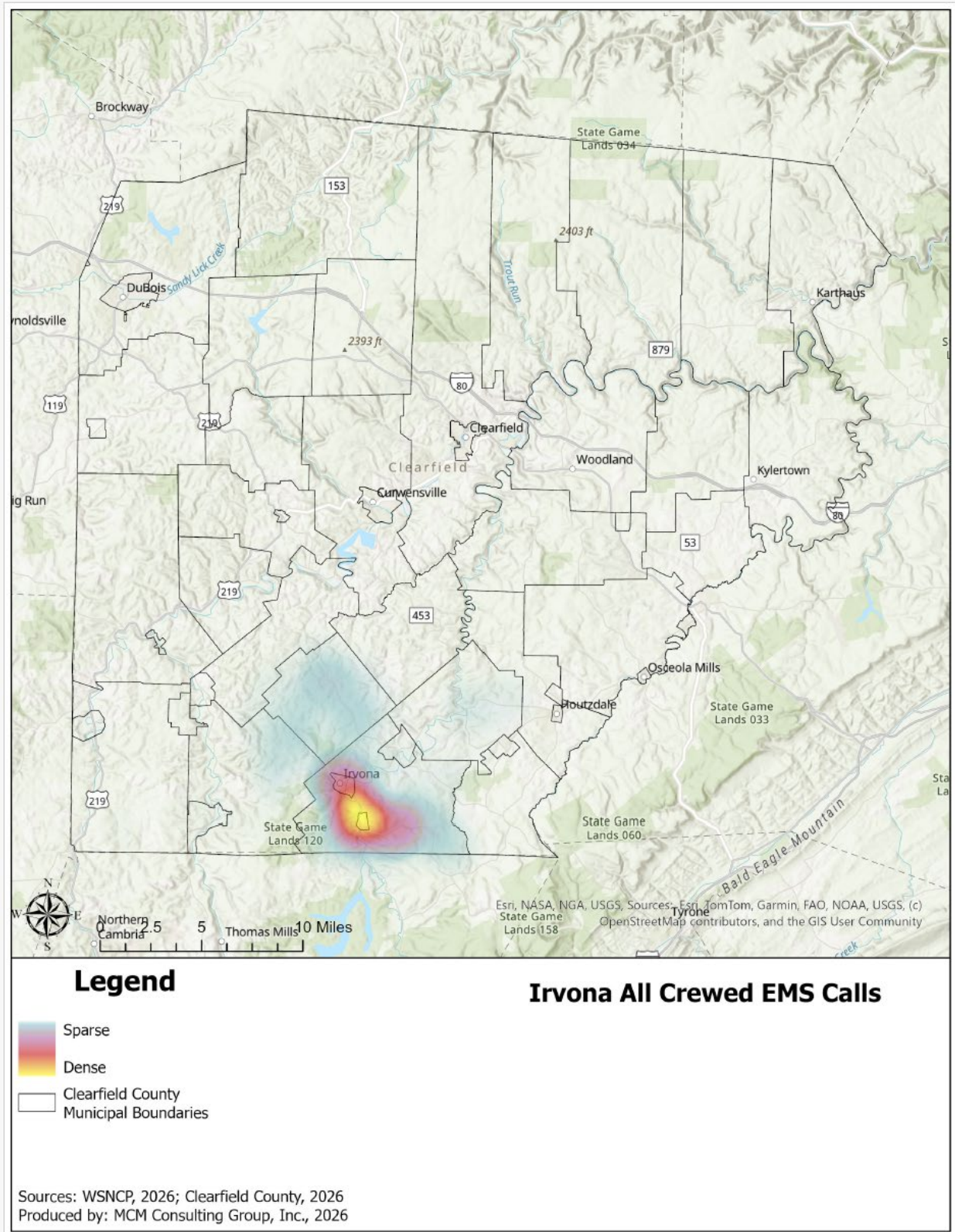


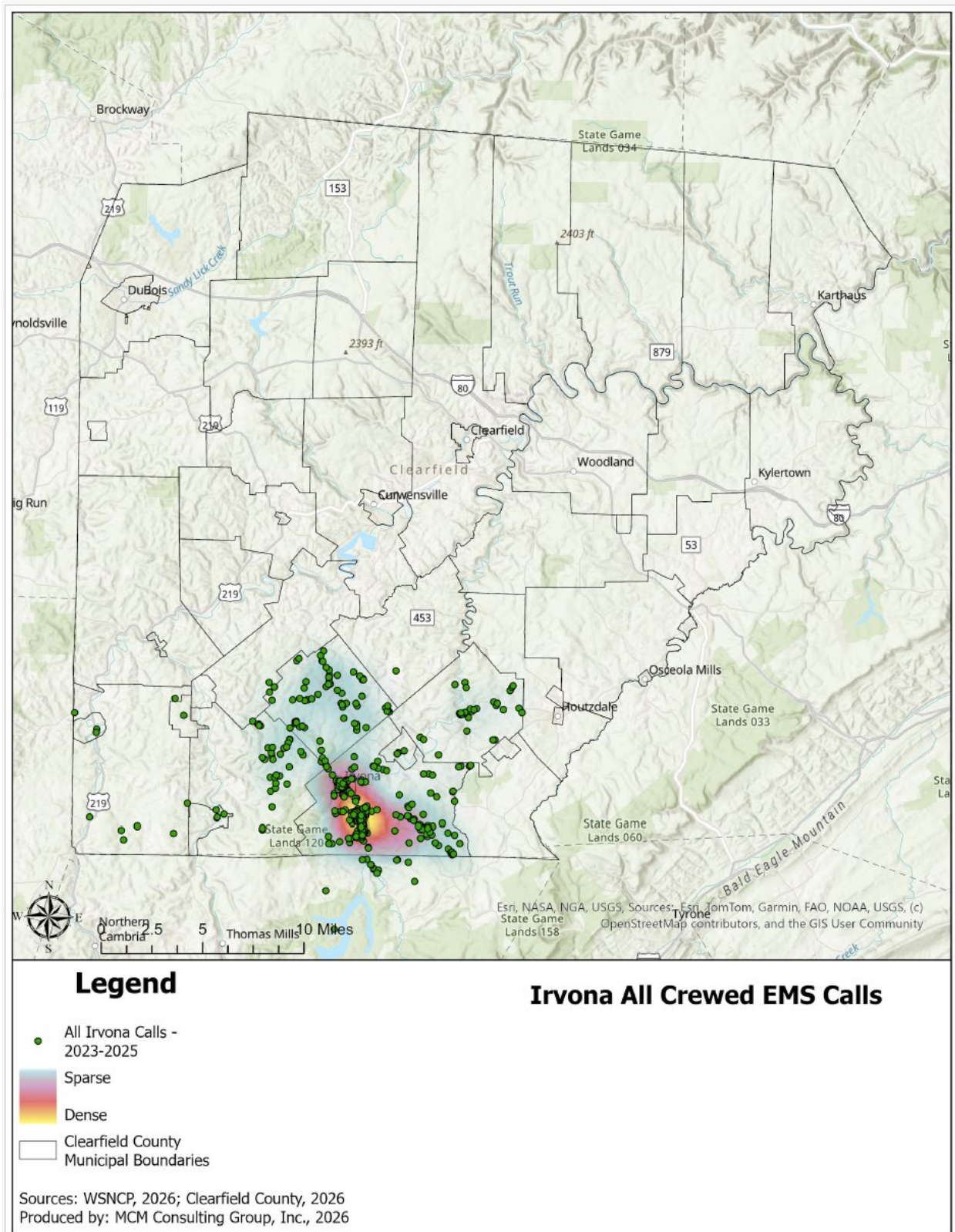
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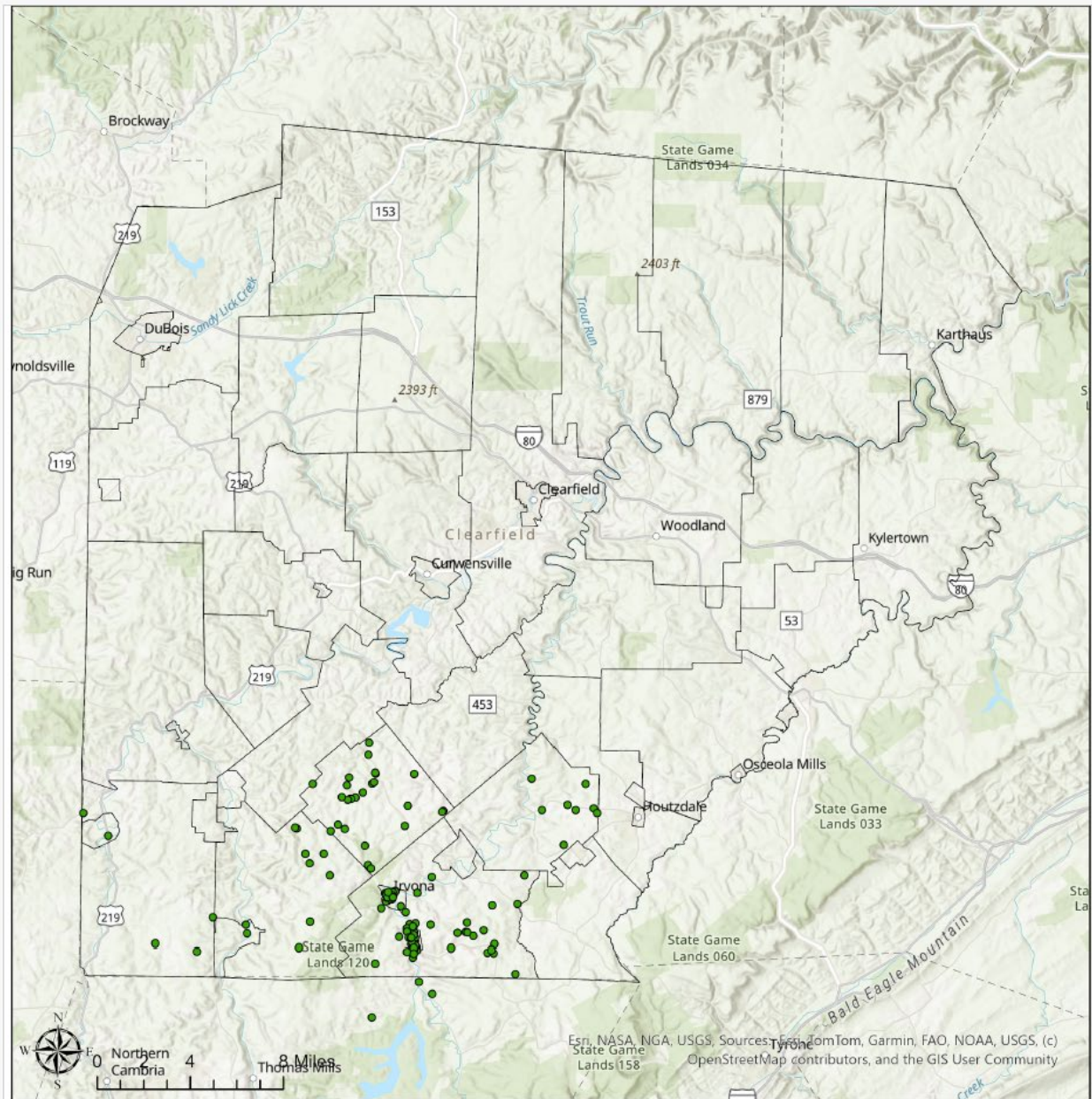
- Karthaus - Did Not Crew Calls 2023-2025
- Clearfield County Municipal Boundaries

Karthaus Did Not Crew EMS Calls

Sources: WSNCP, 2026; Clearfield County, 2026
Produced by: MCM Consulting Group, Inc. 2026





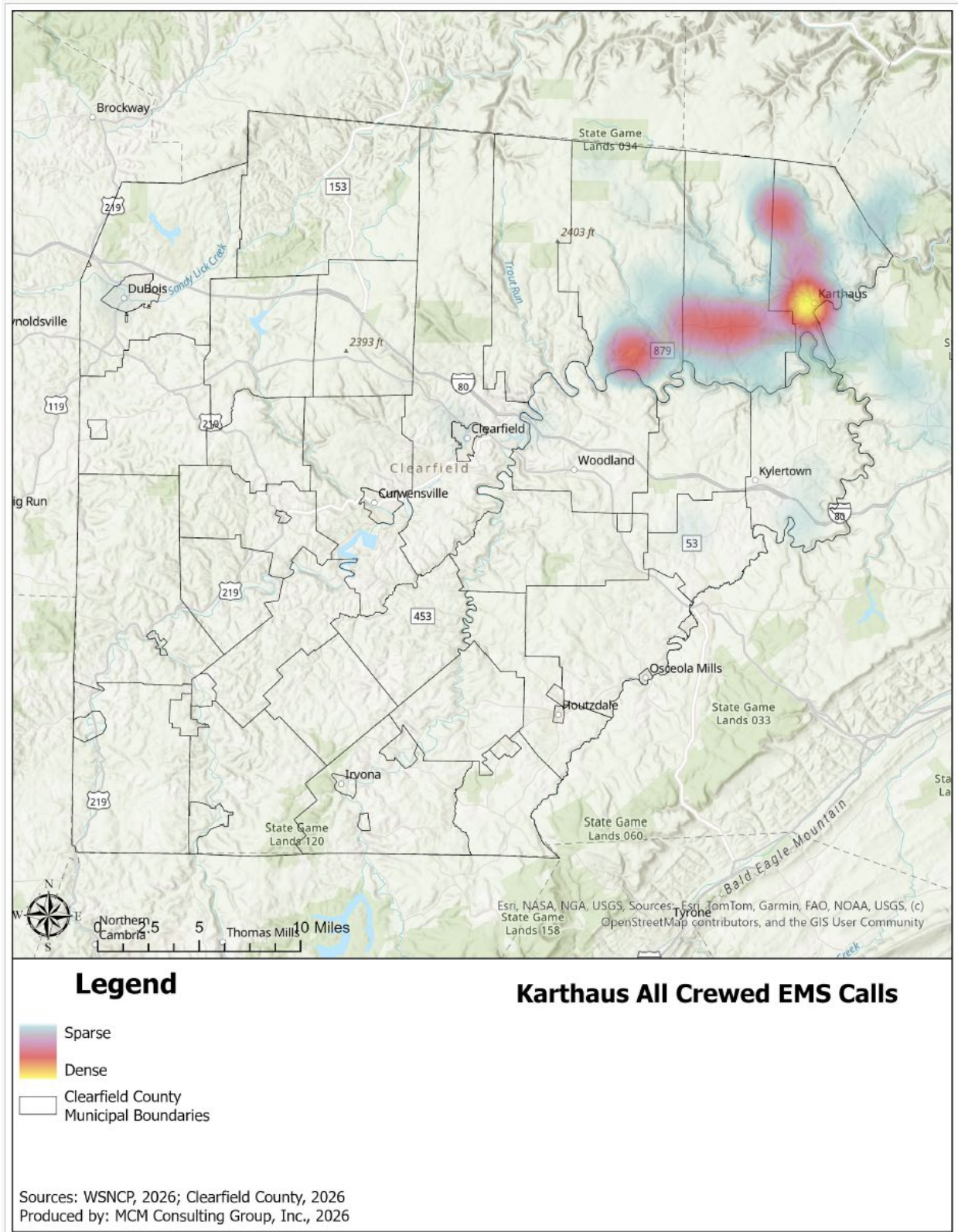


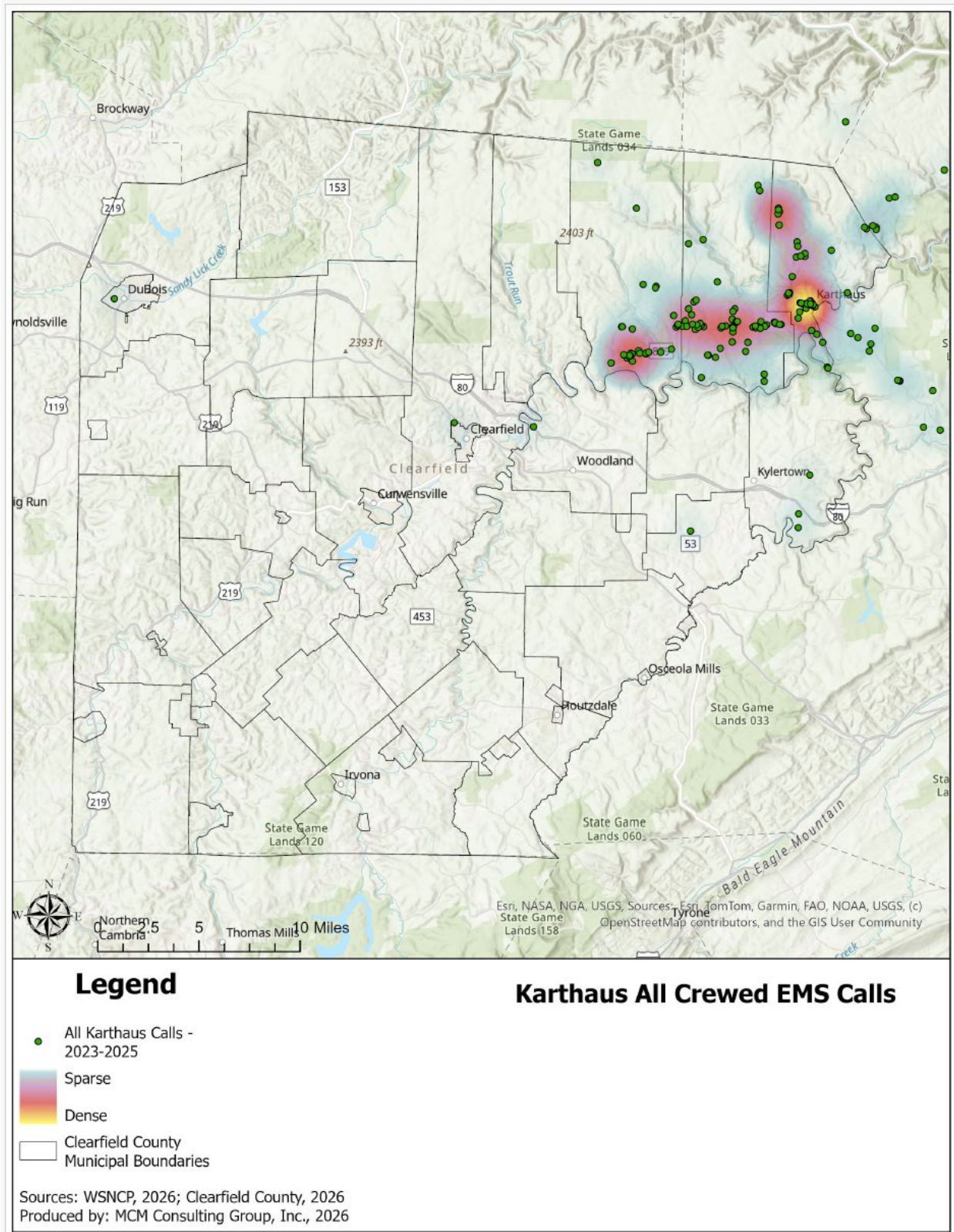
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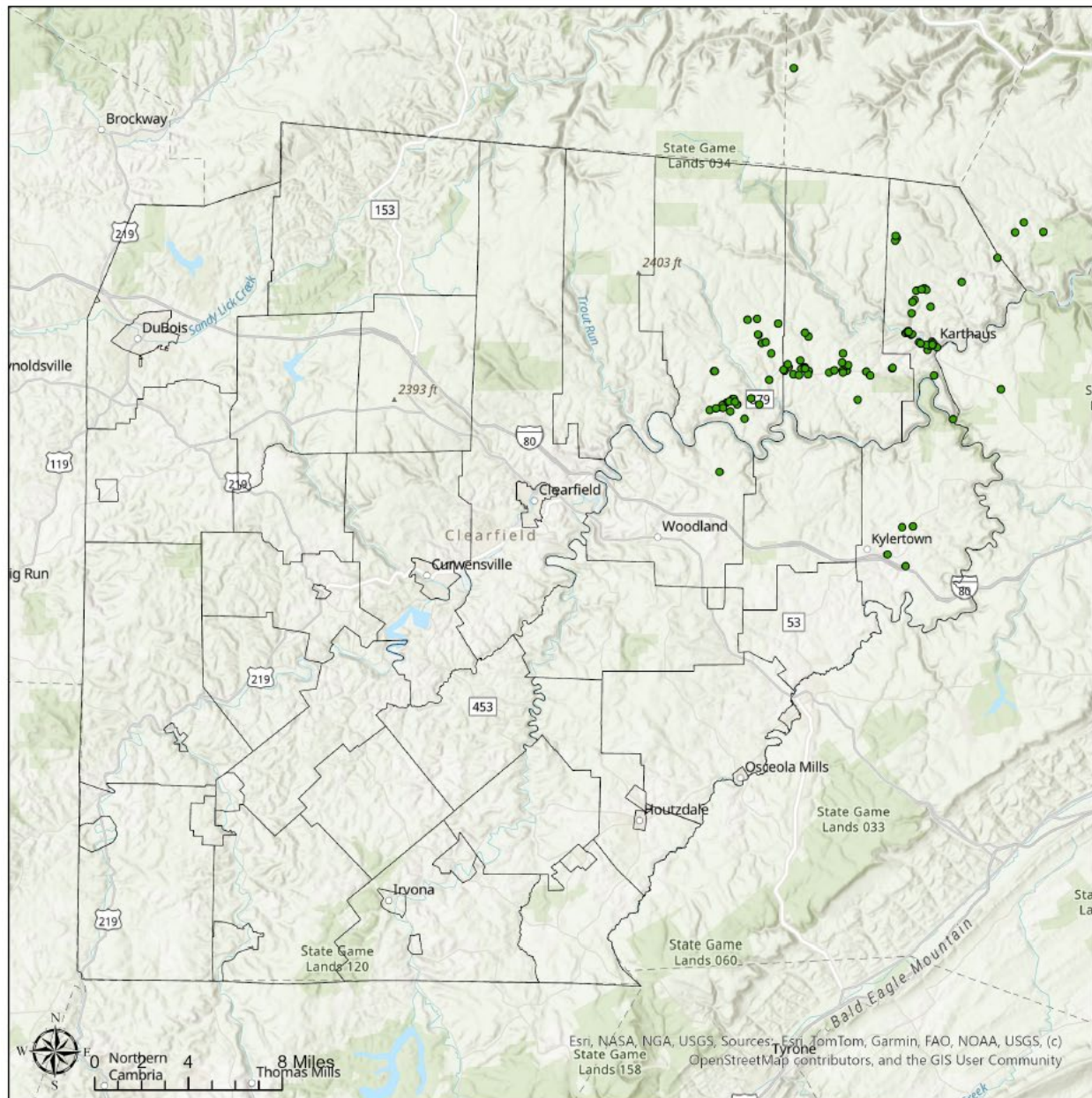
- Irvona - Did Not Crew Calls 2023-2025
- Clearfield County Municipal Boundaries

Irvona Did Not Crew EMS Calls

Sources: WSNCP, 2026; Clearfield County, 2026
Produced by: MCM Consulting Group, Inc. 2026





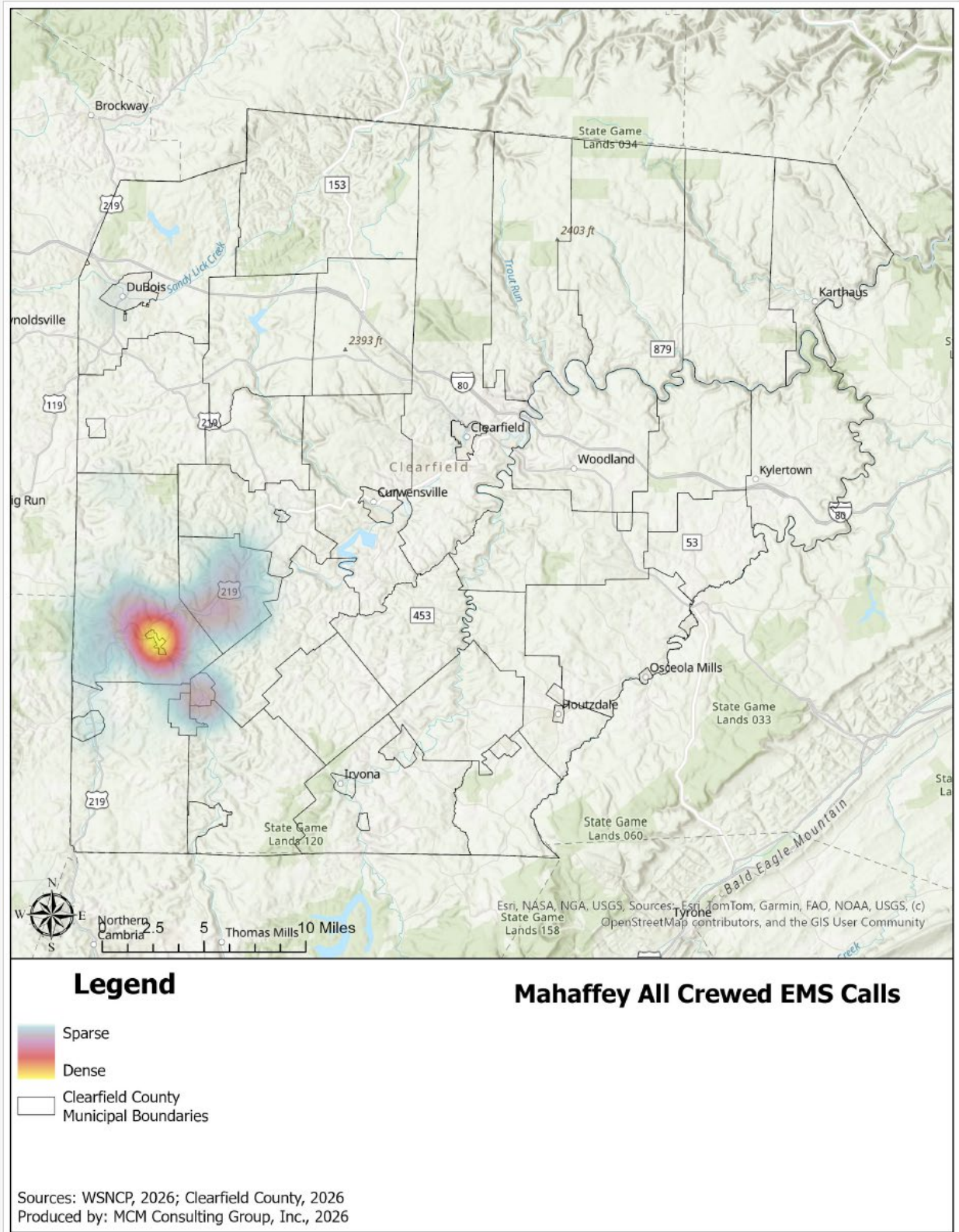


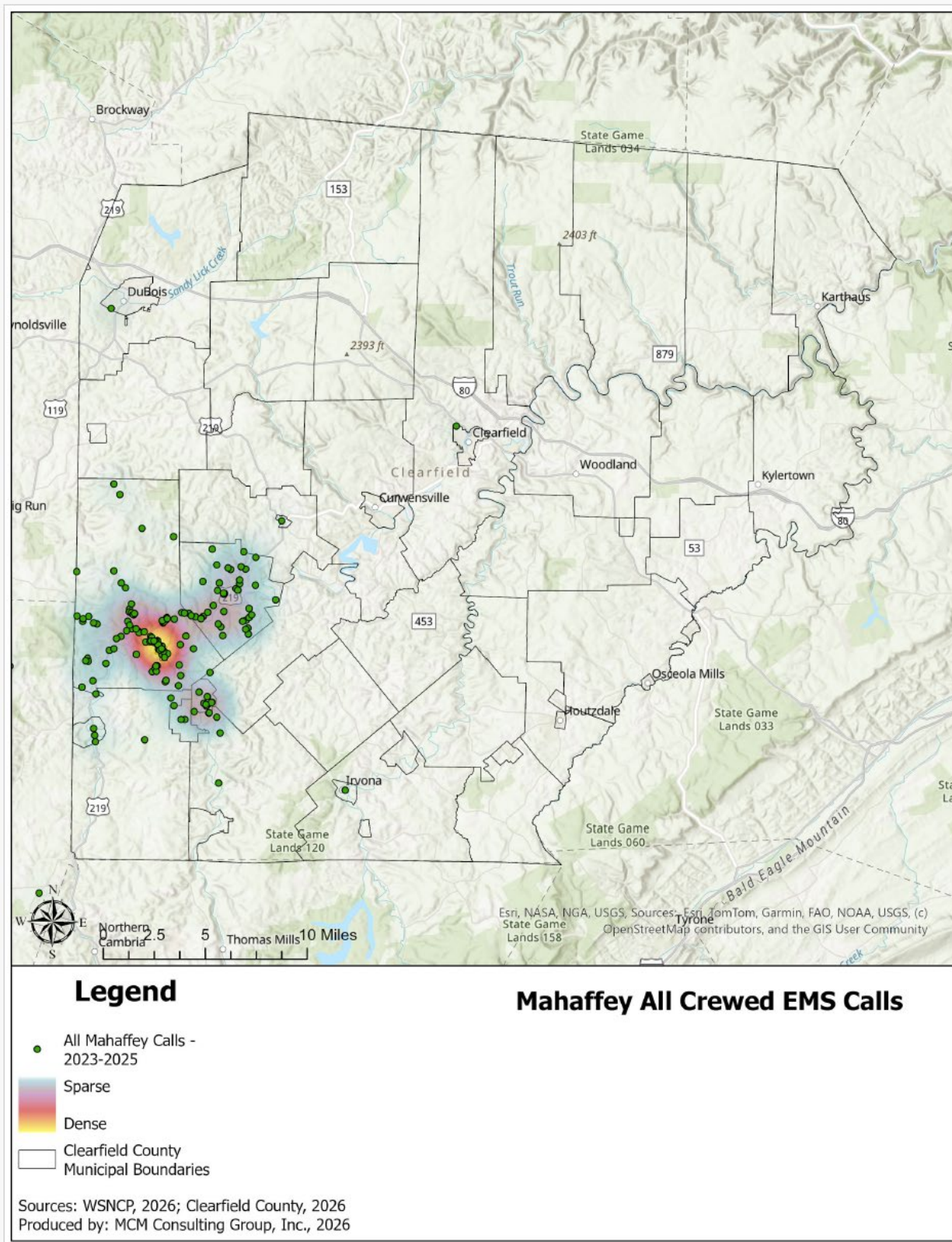
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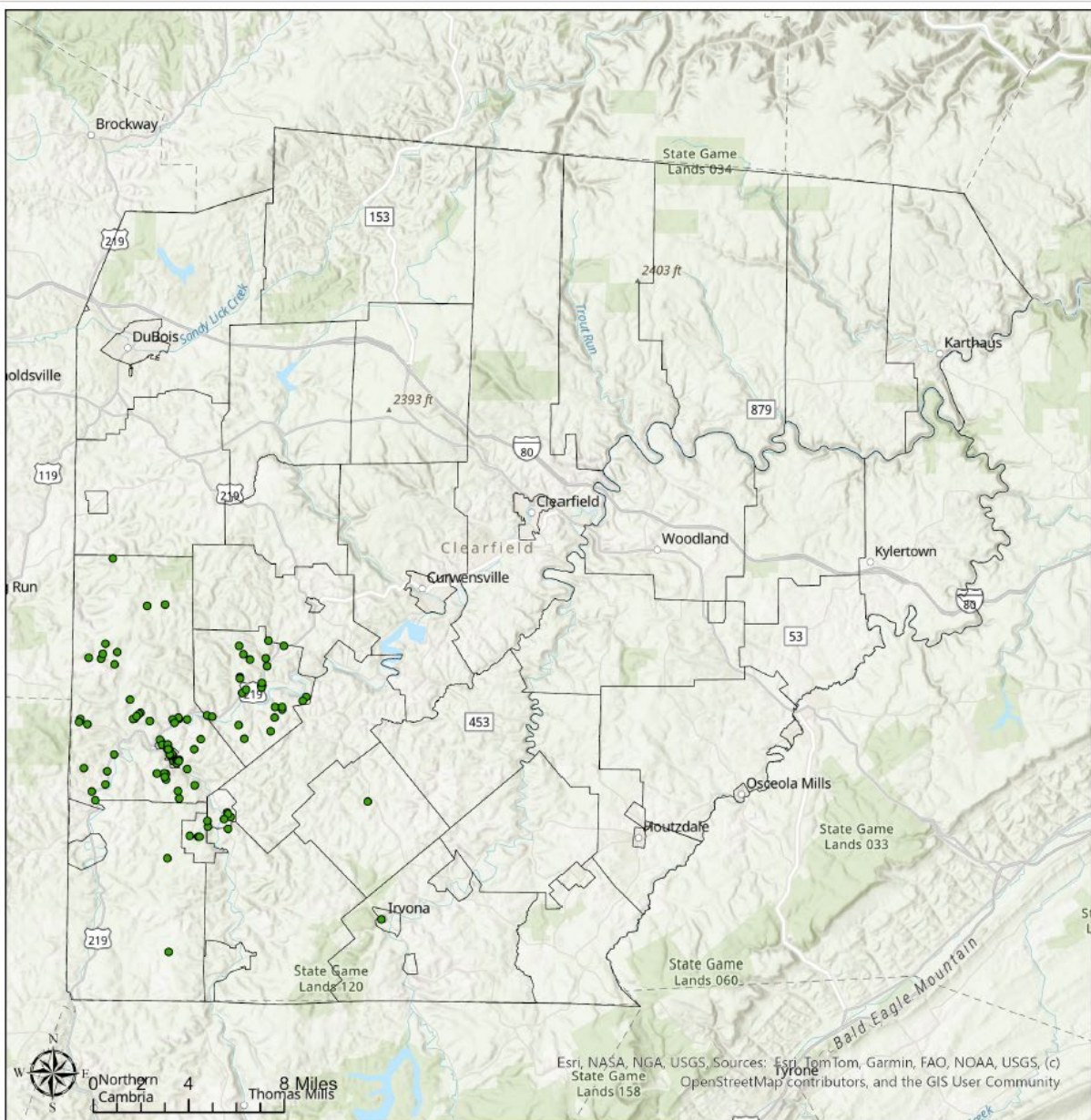
- Karthaus - Did Not Crew
Calls 2023-2025
- Clearfield County
Municipal Boundaries

Karthaus Did Not Crew EMS Calls

Sources: WSNCP, 2026; Clearfield County, 2026
Produced by: MCM Consulting Group, Inc. 2026





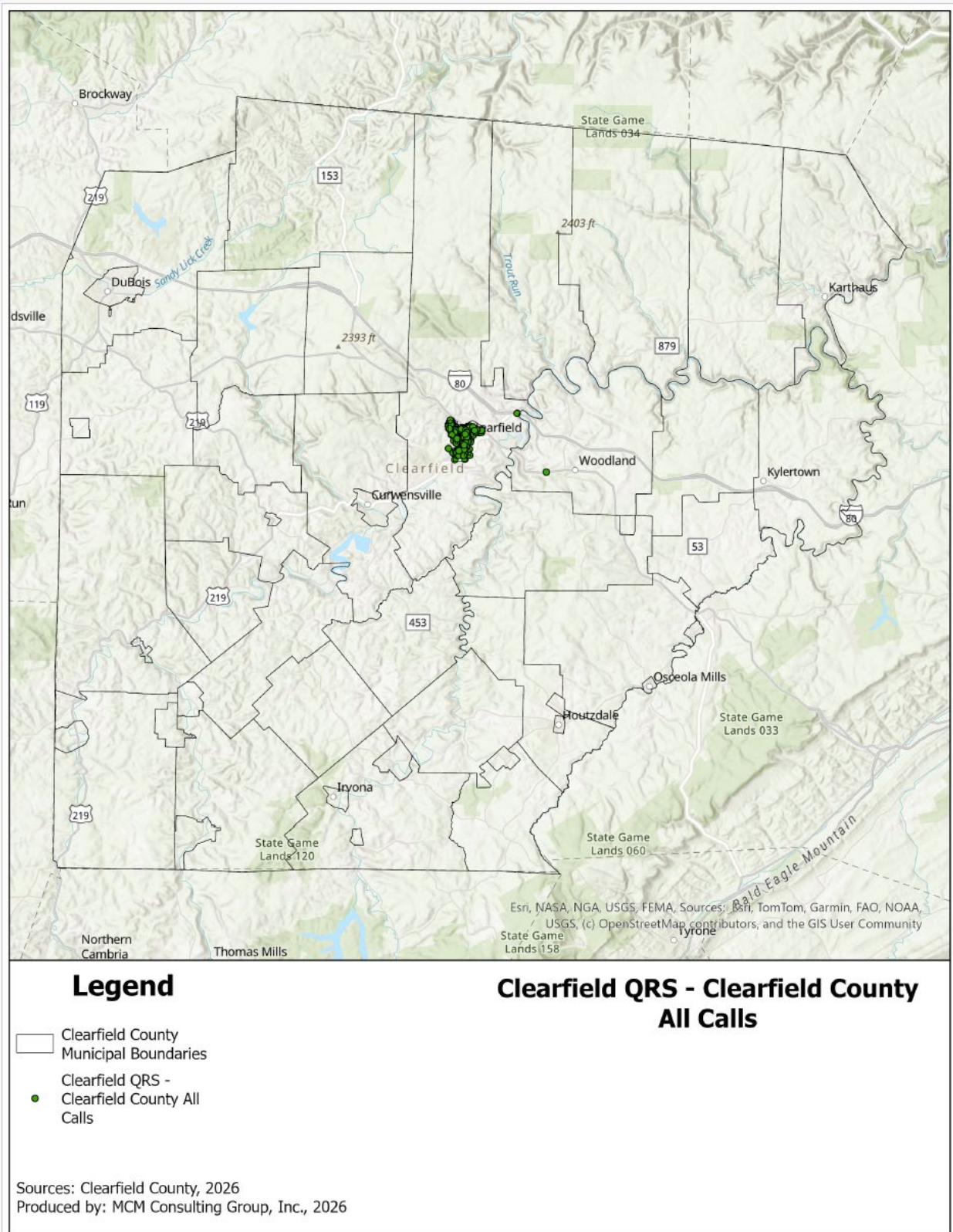


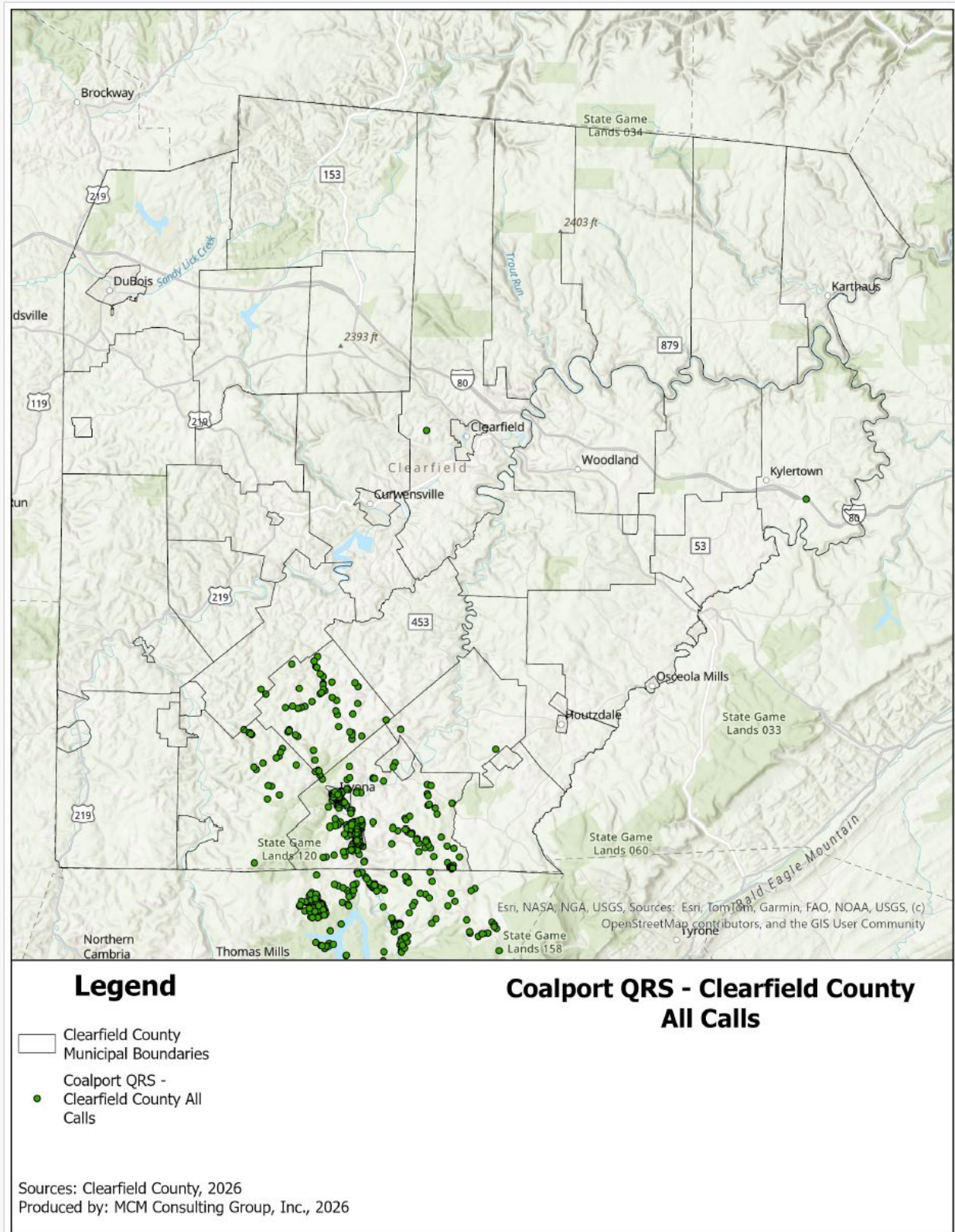
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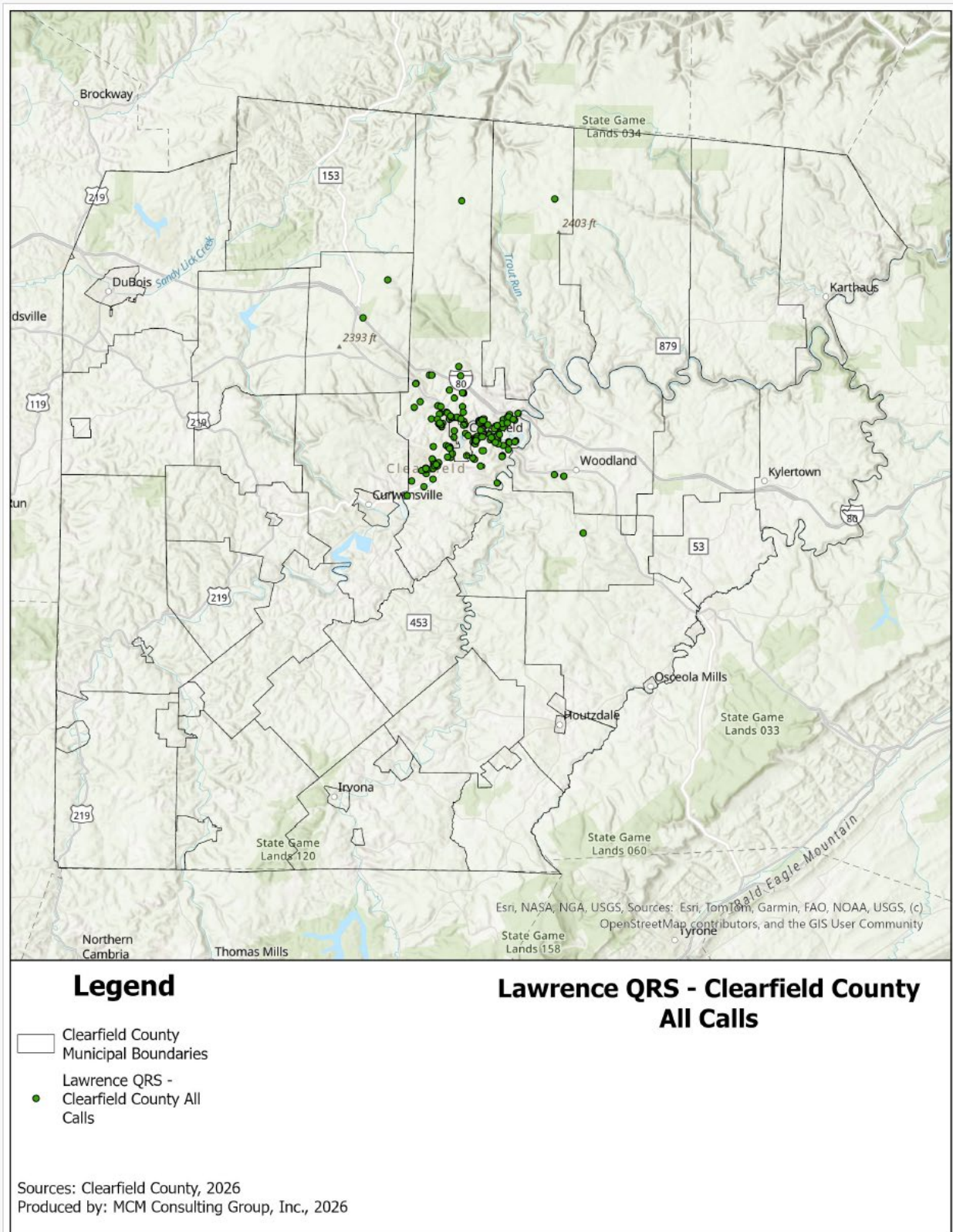
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- Clearfield County Municipal Boundaries

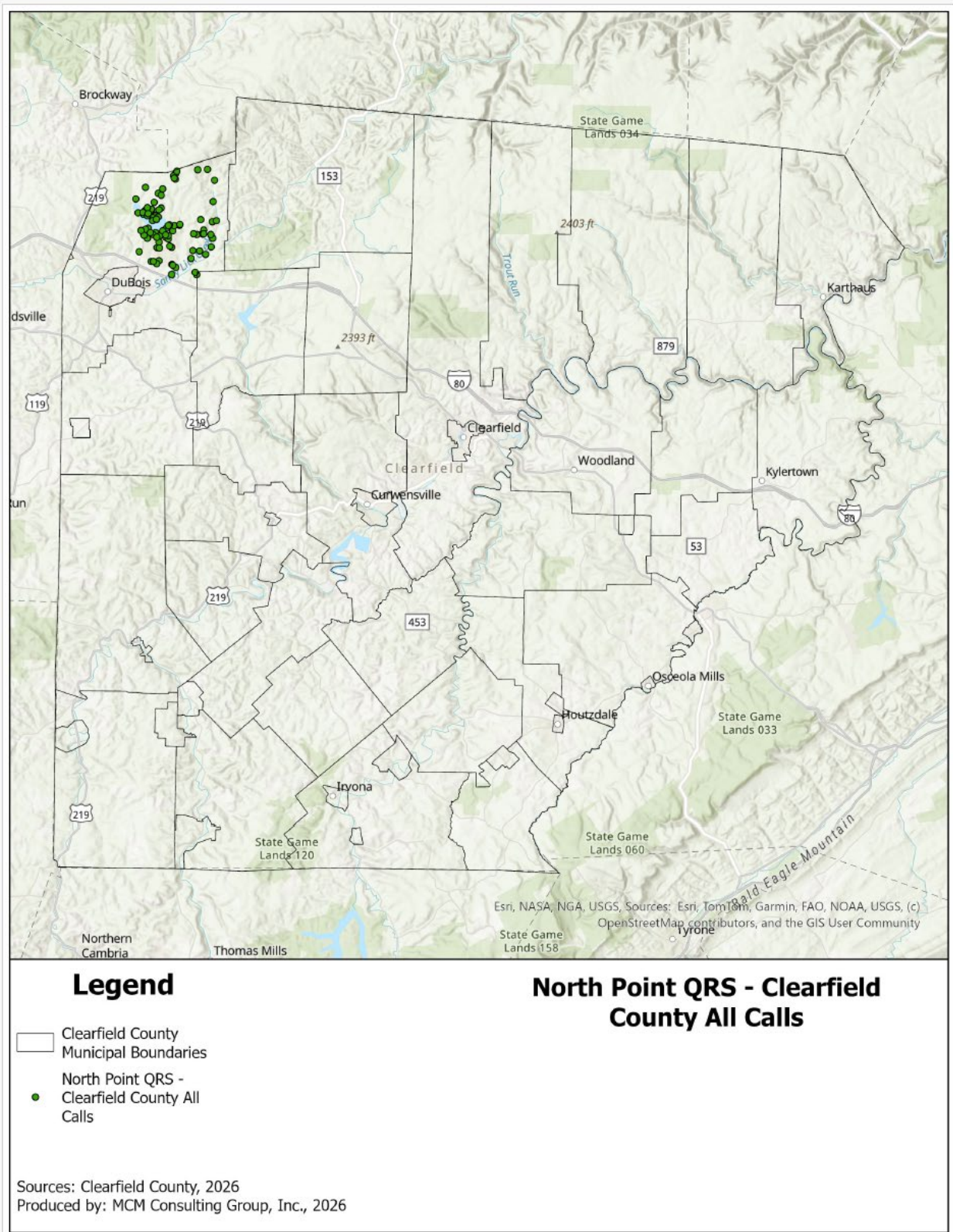
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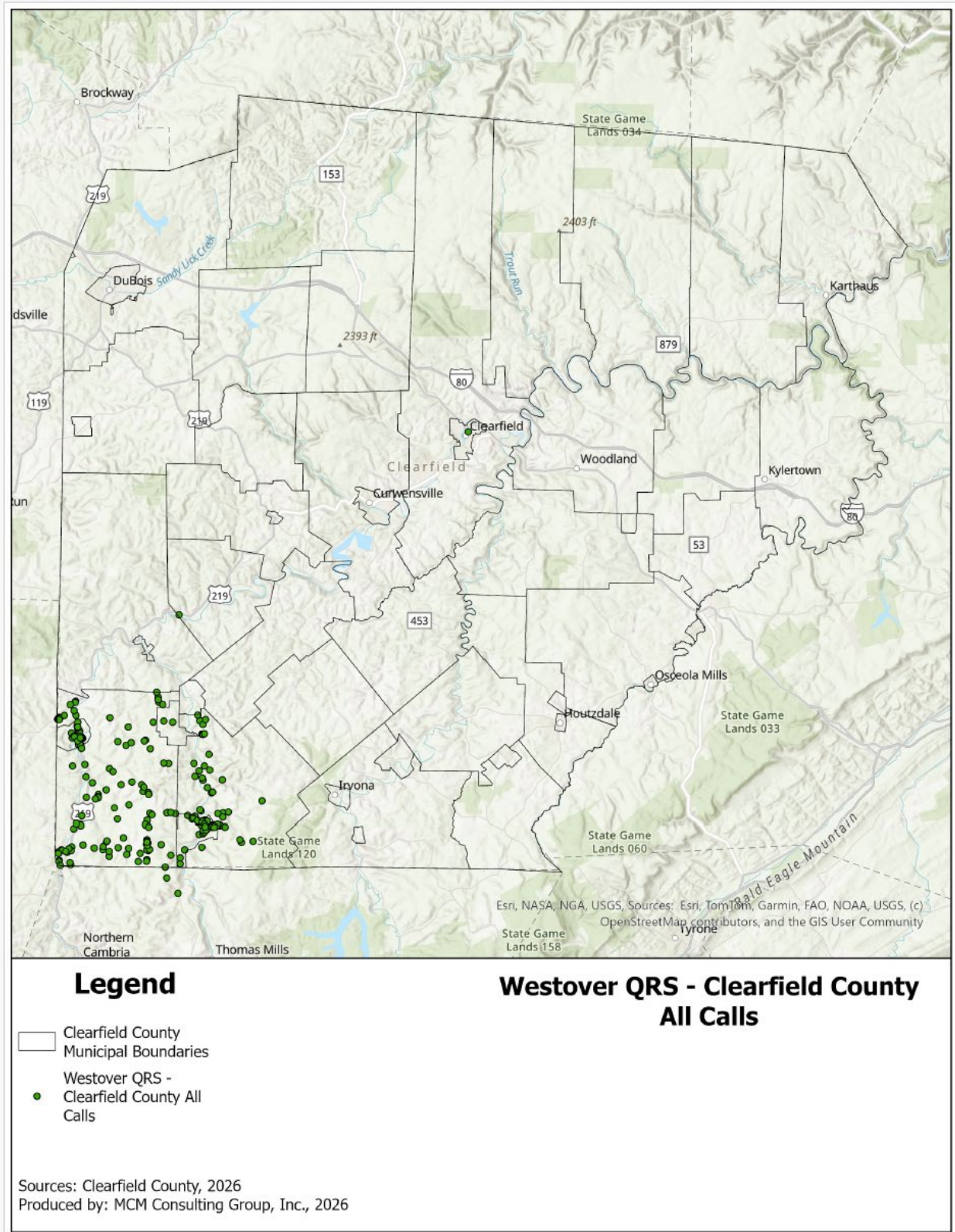
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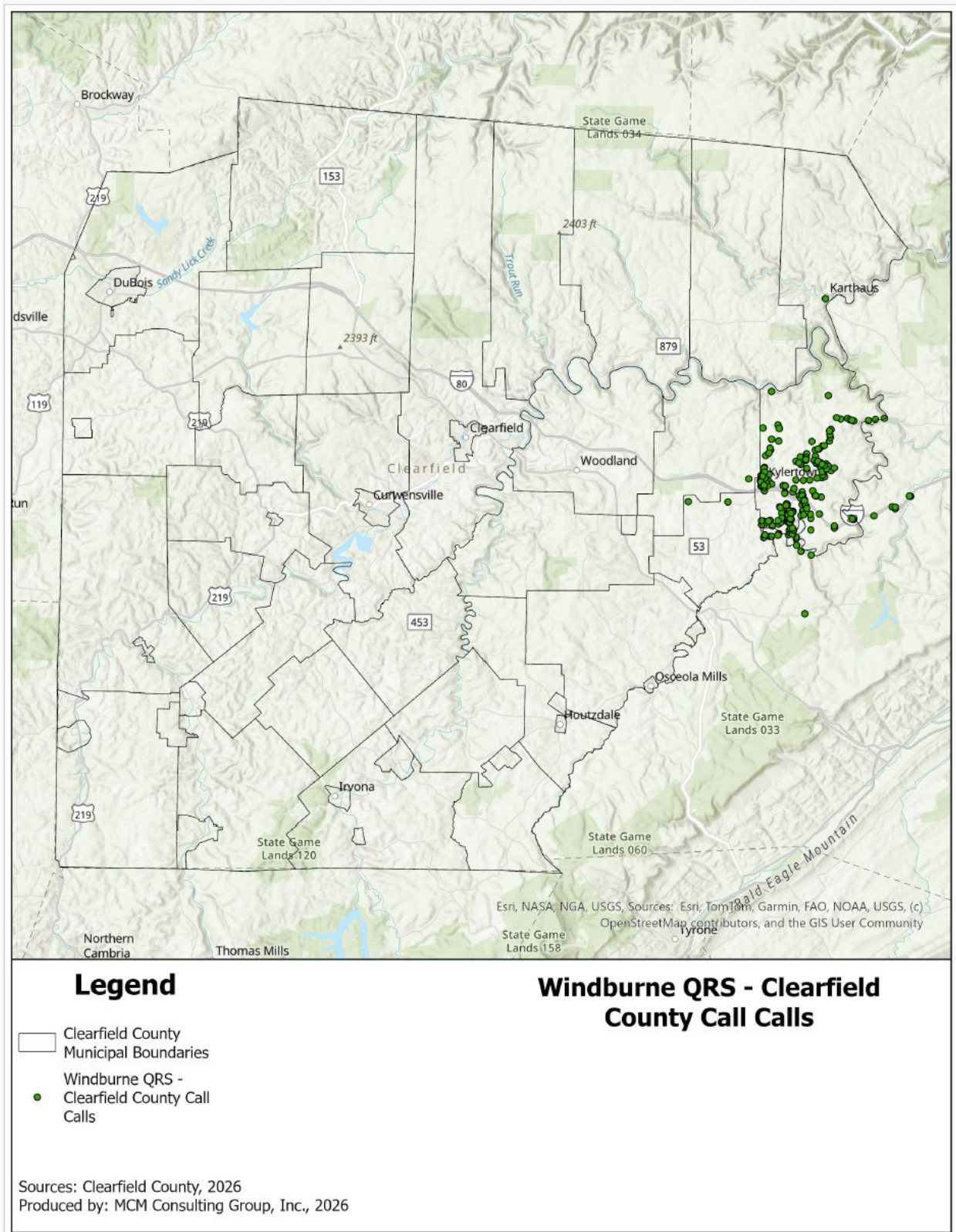


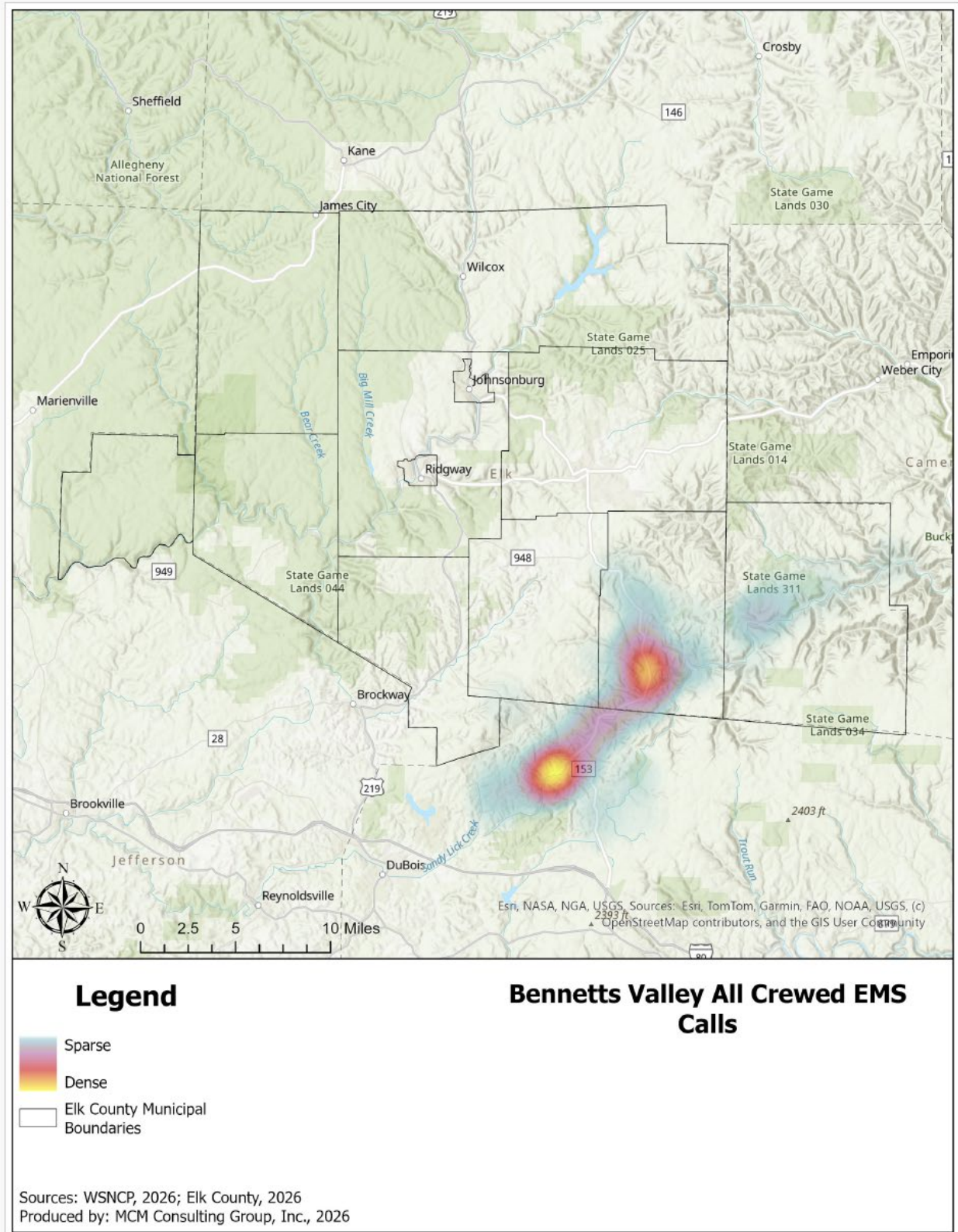


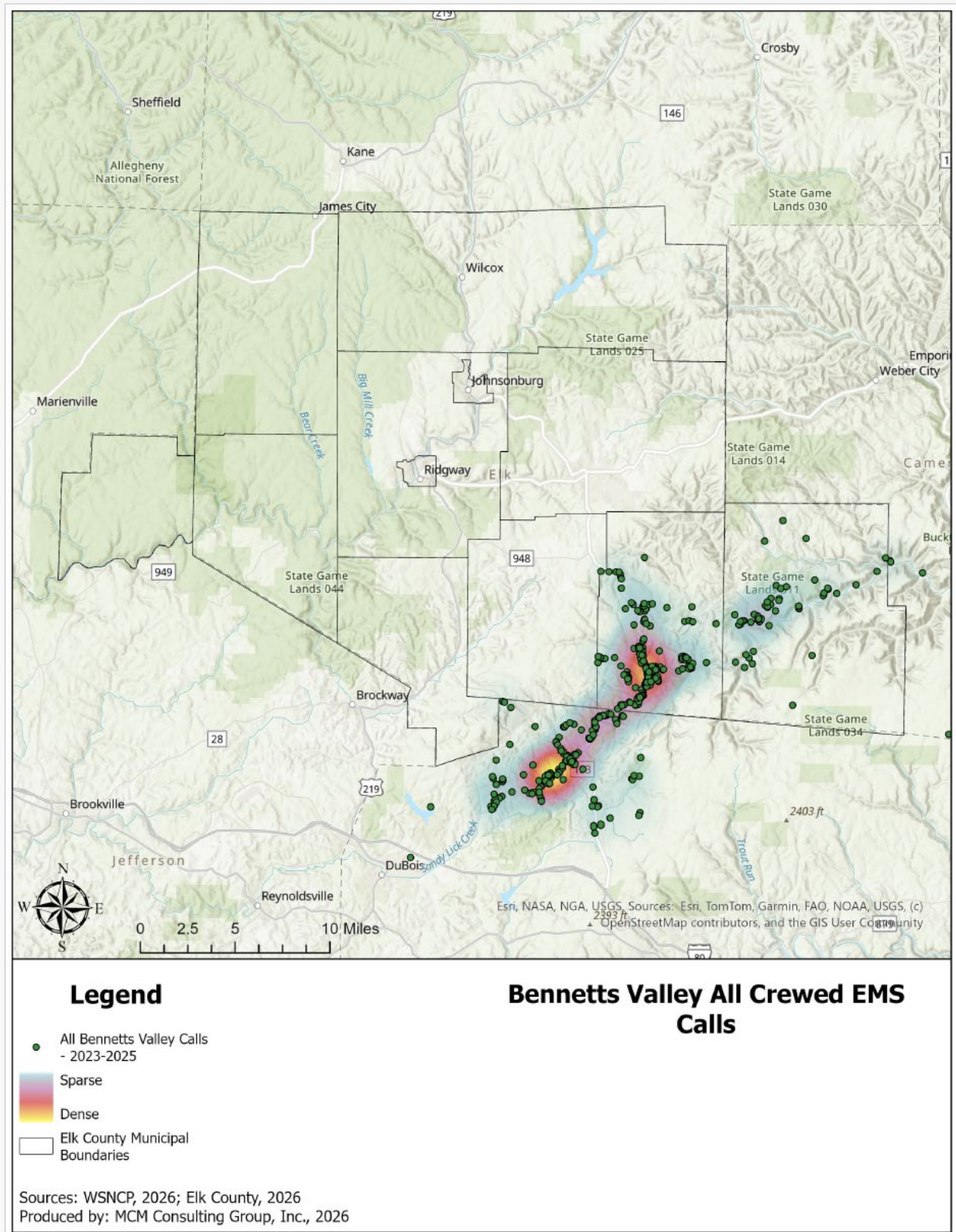


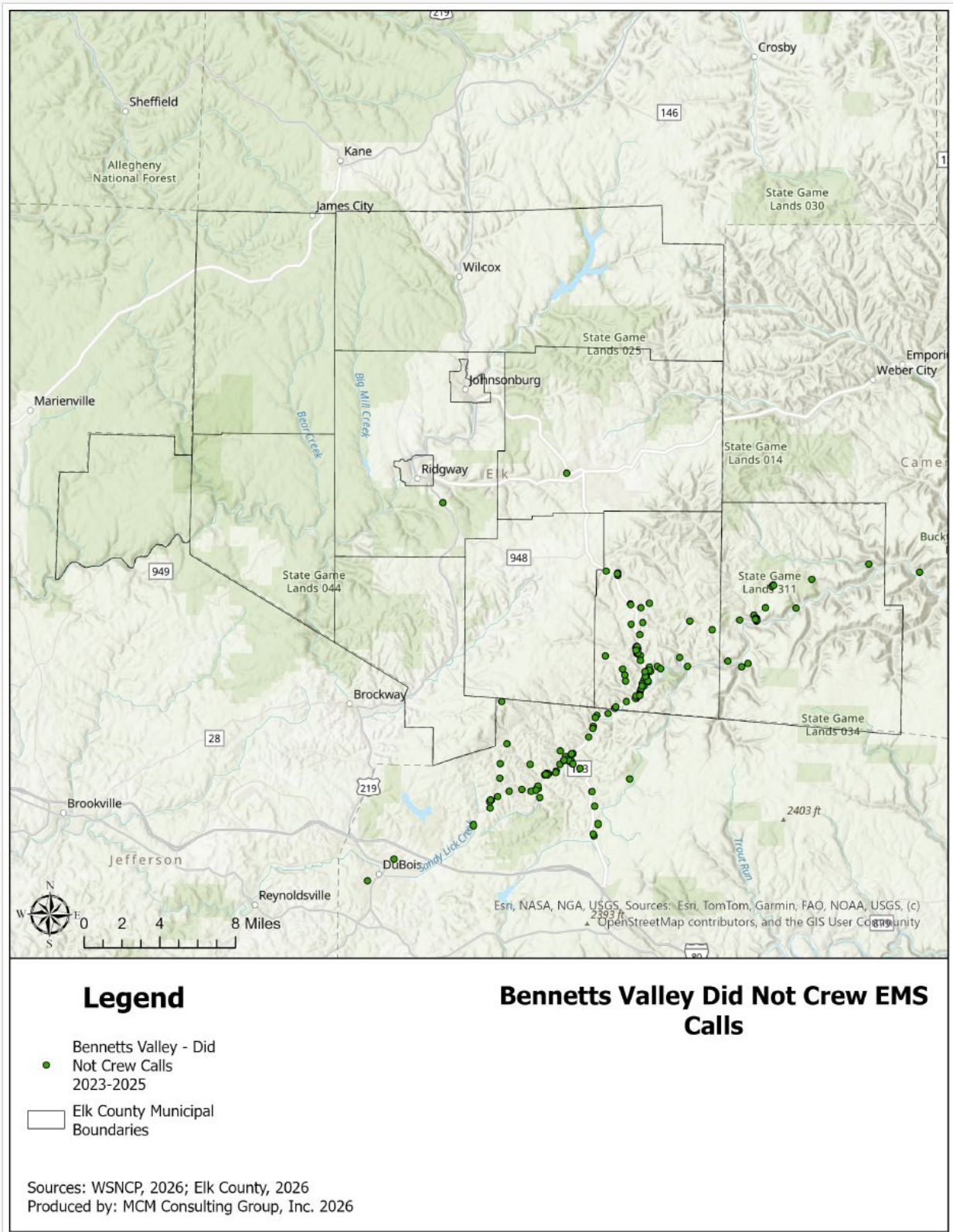


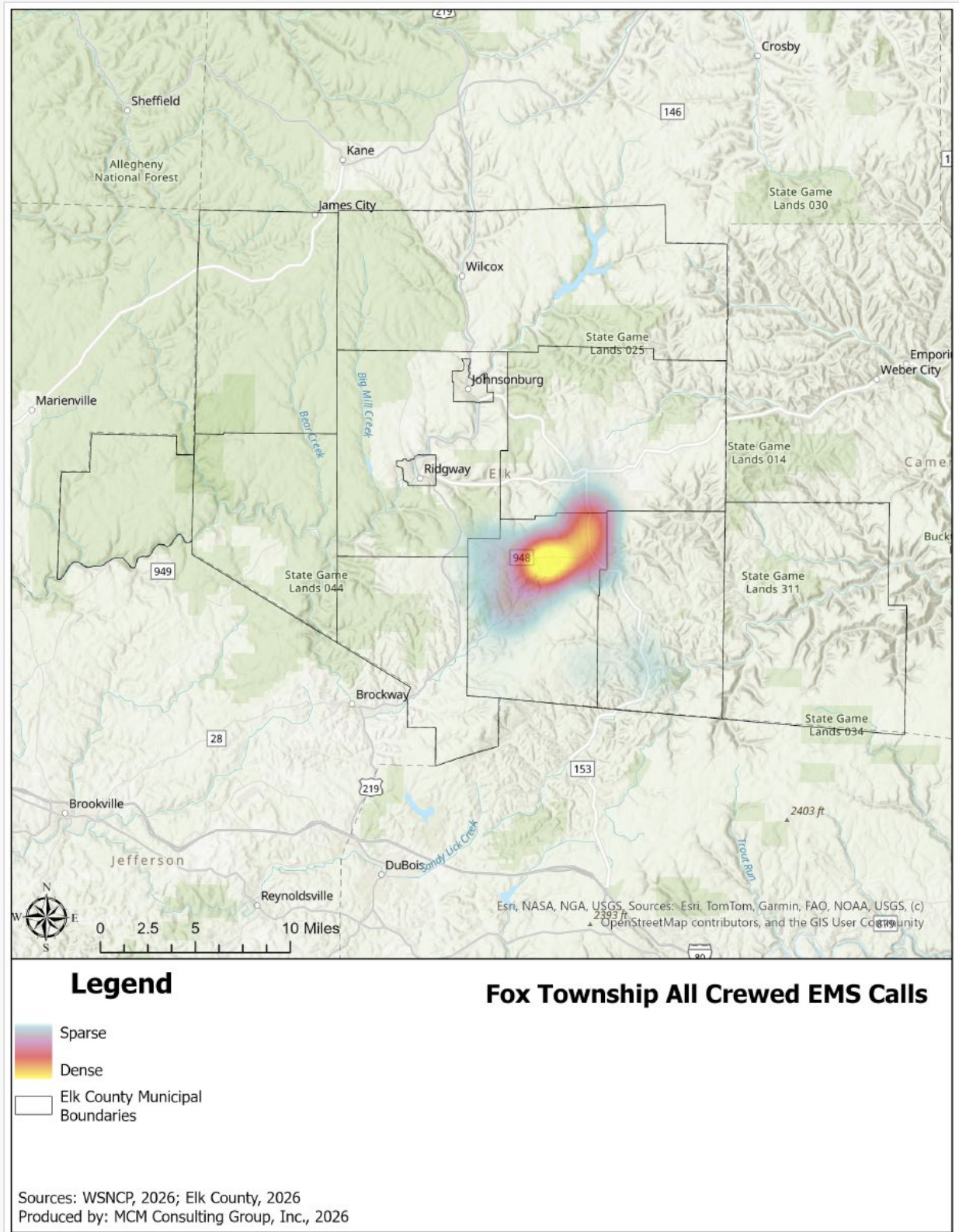


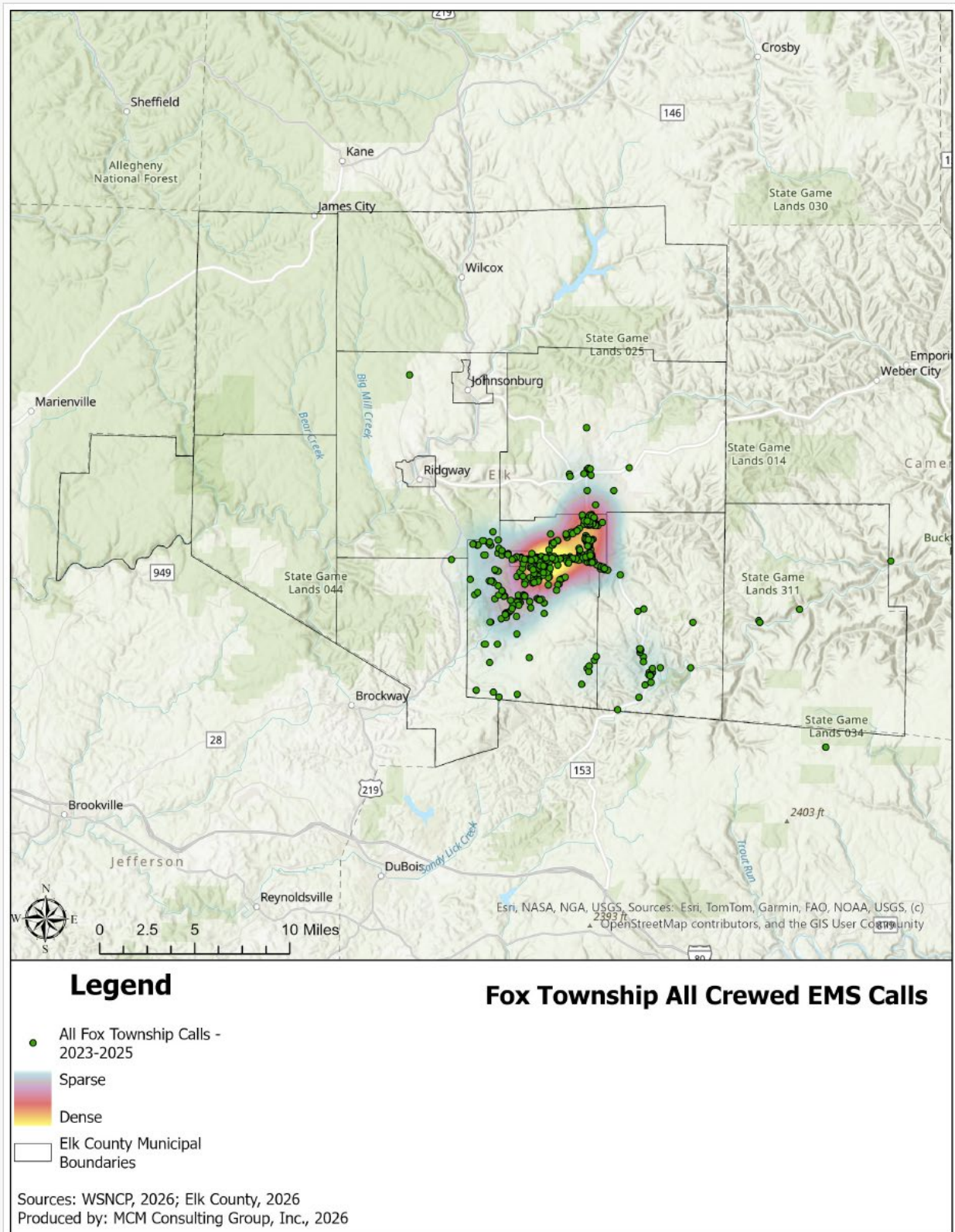


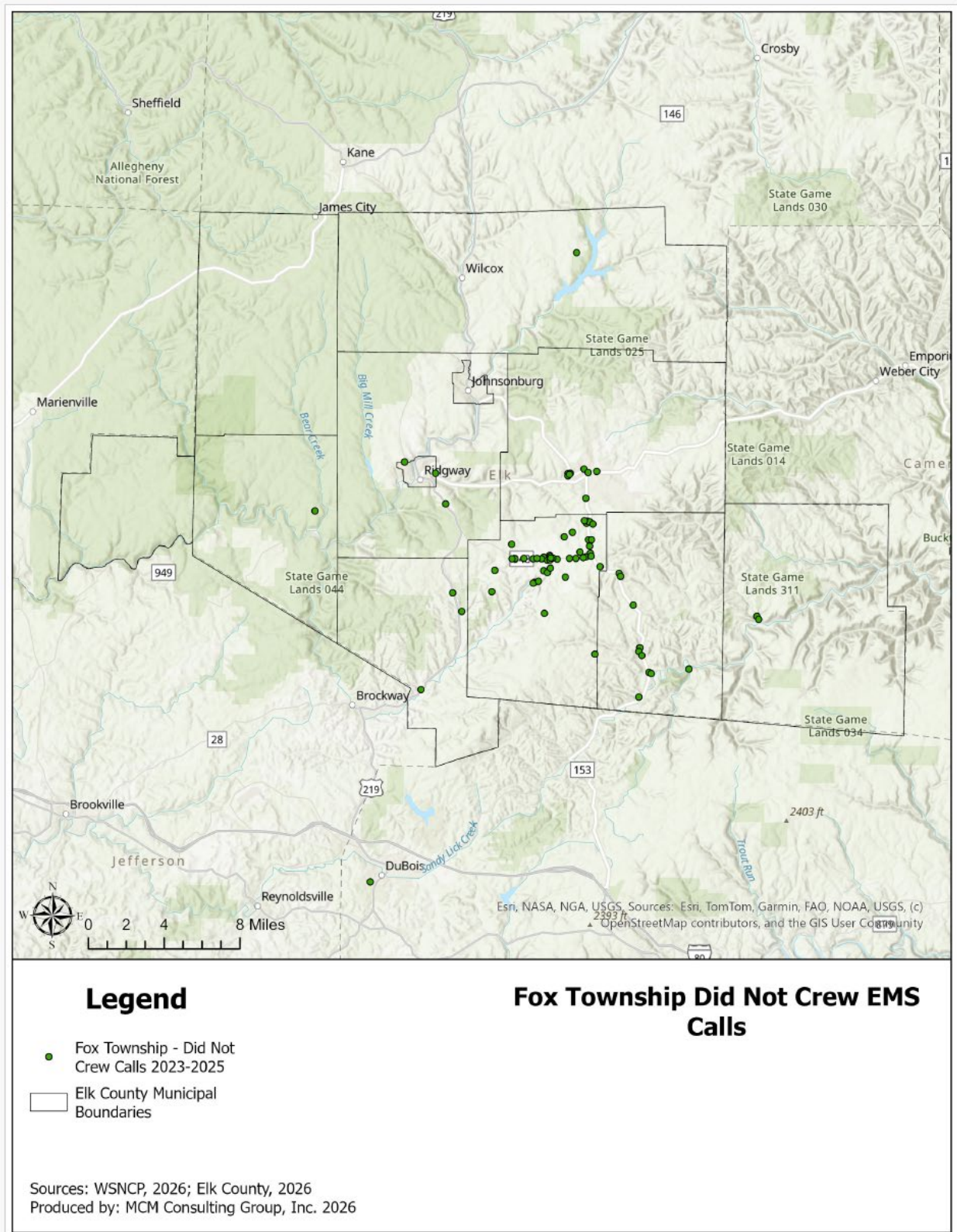


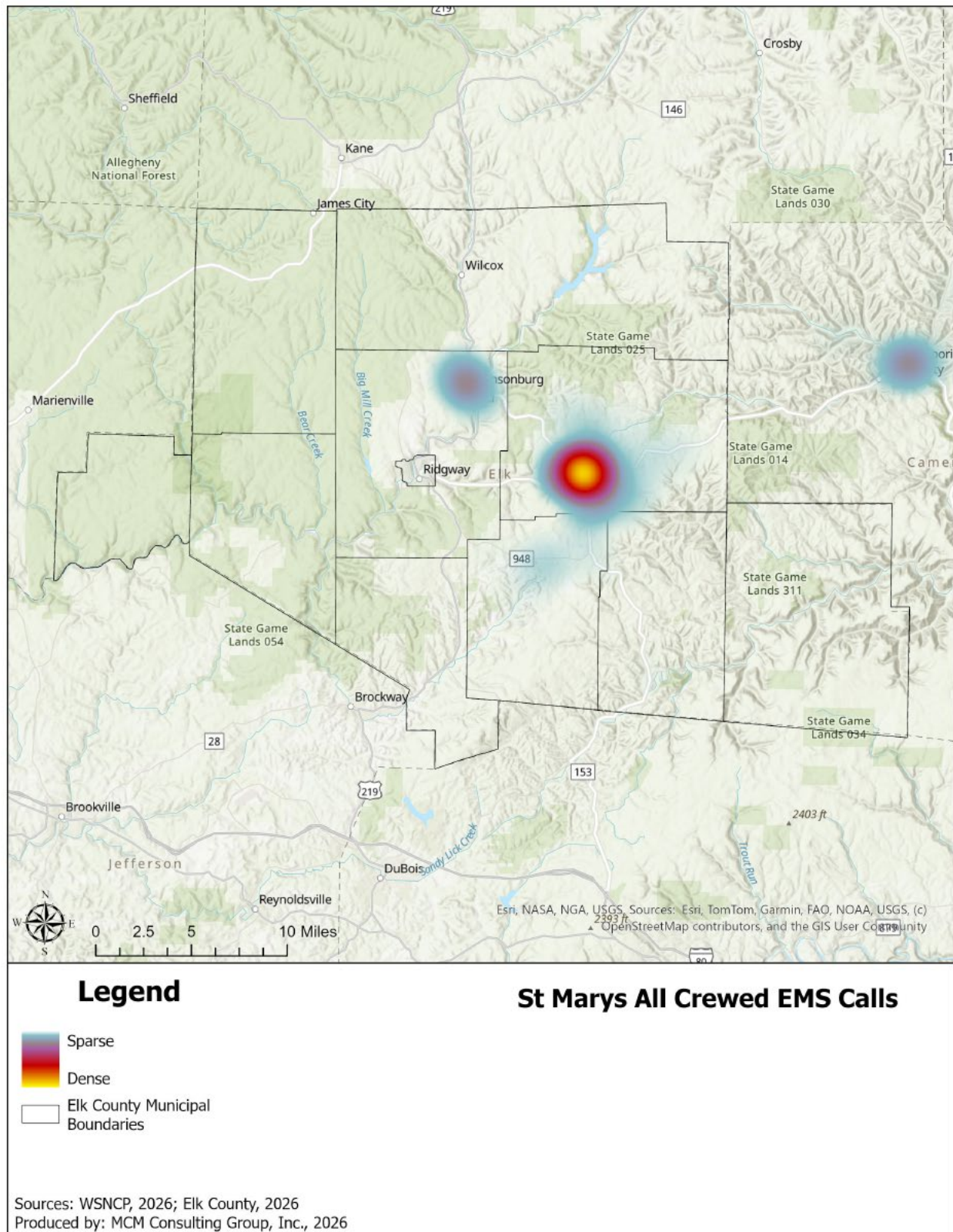


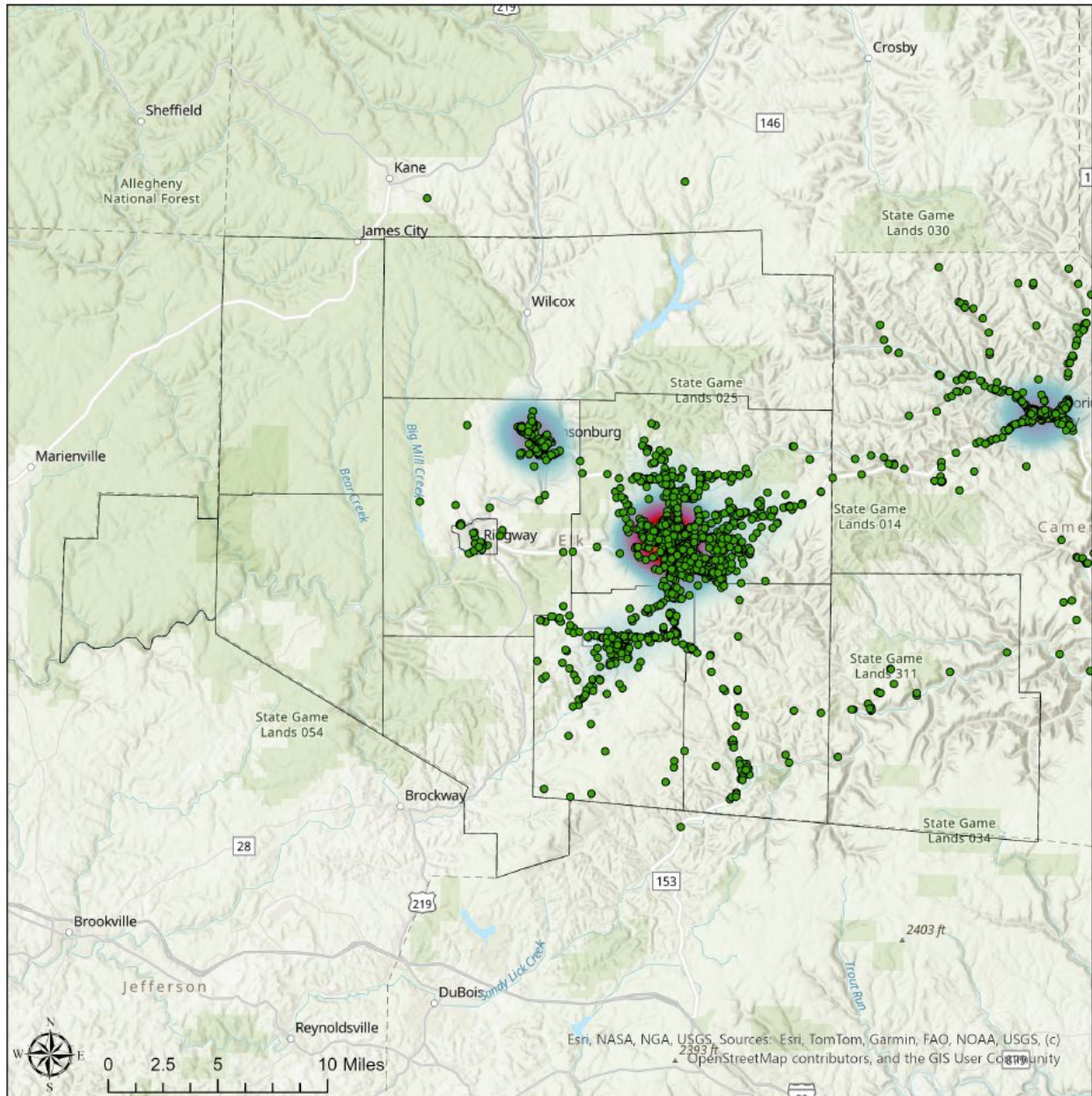










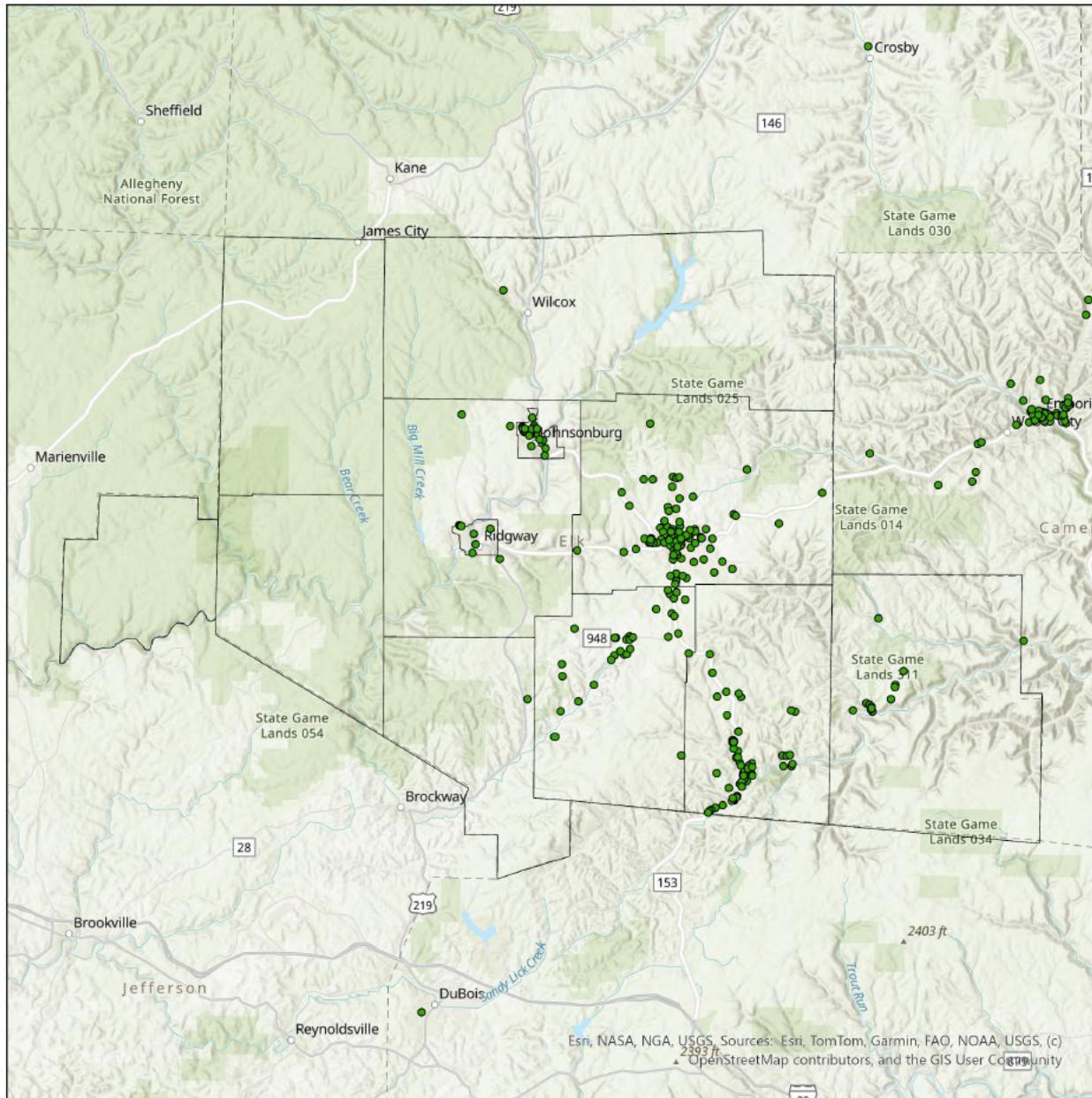


Legend

- All St Marys Calls - 2023-2025
- Sparse
- Dense
- Elk County Municipal Boundaries

Sources: WSNCP, 2026; Elk County, 2026
Produced by: MCM Consulting Group, Inc., 2026

St Marys All Crewed EMS Calls

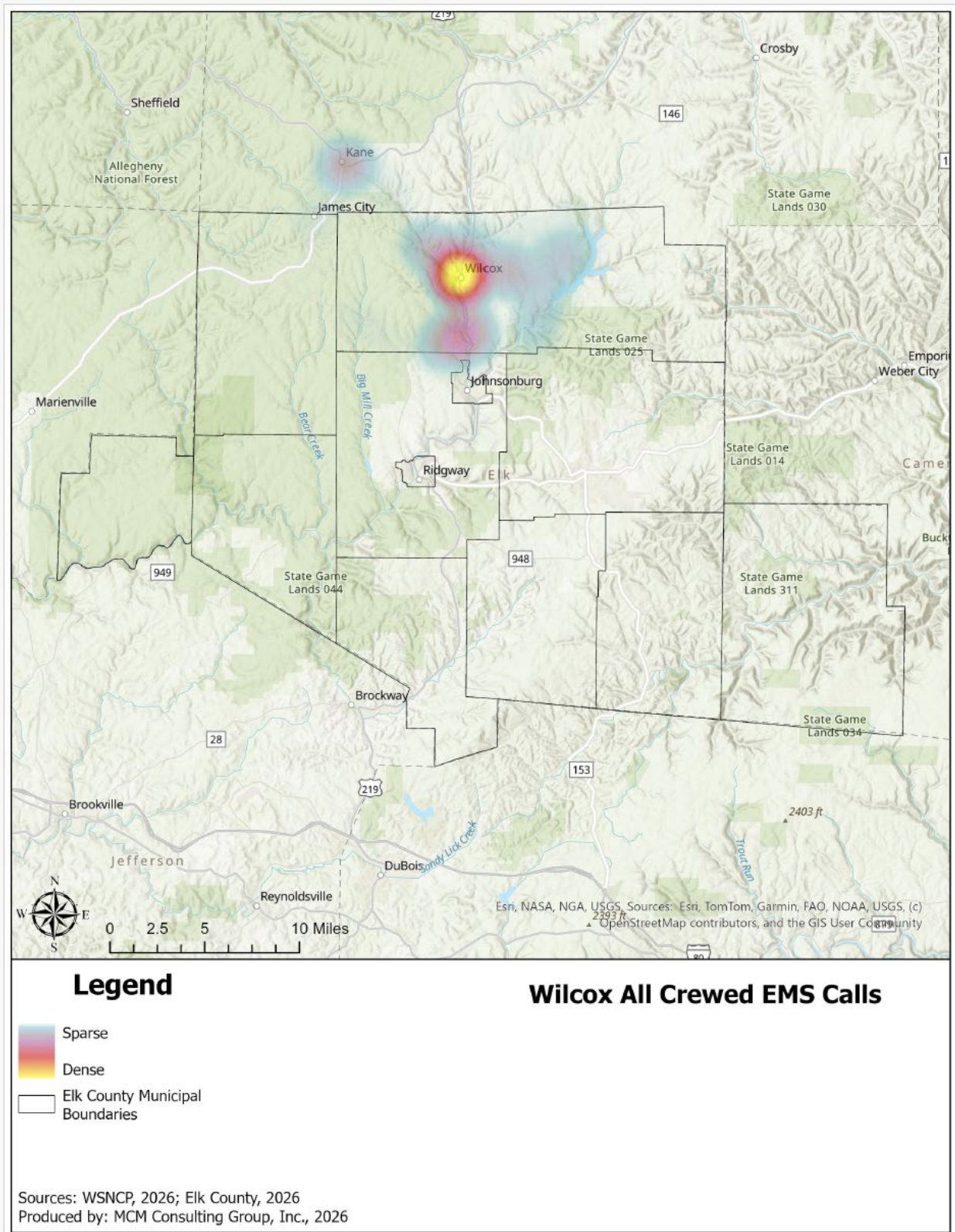


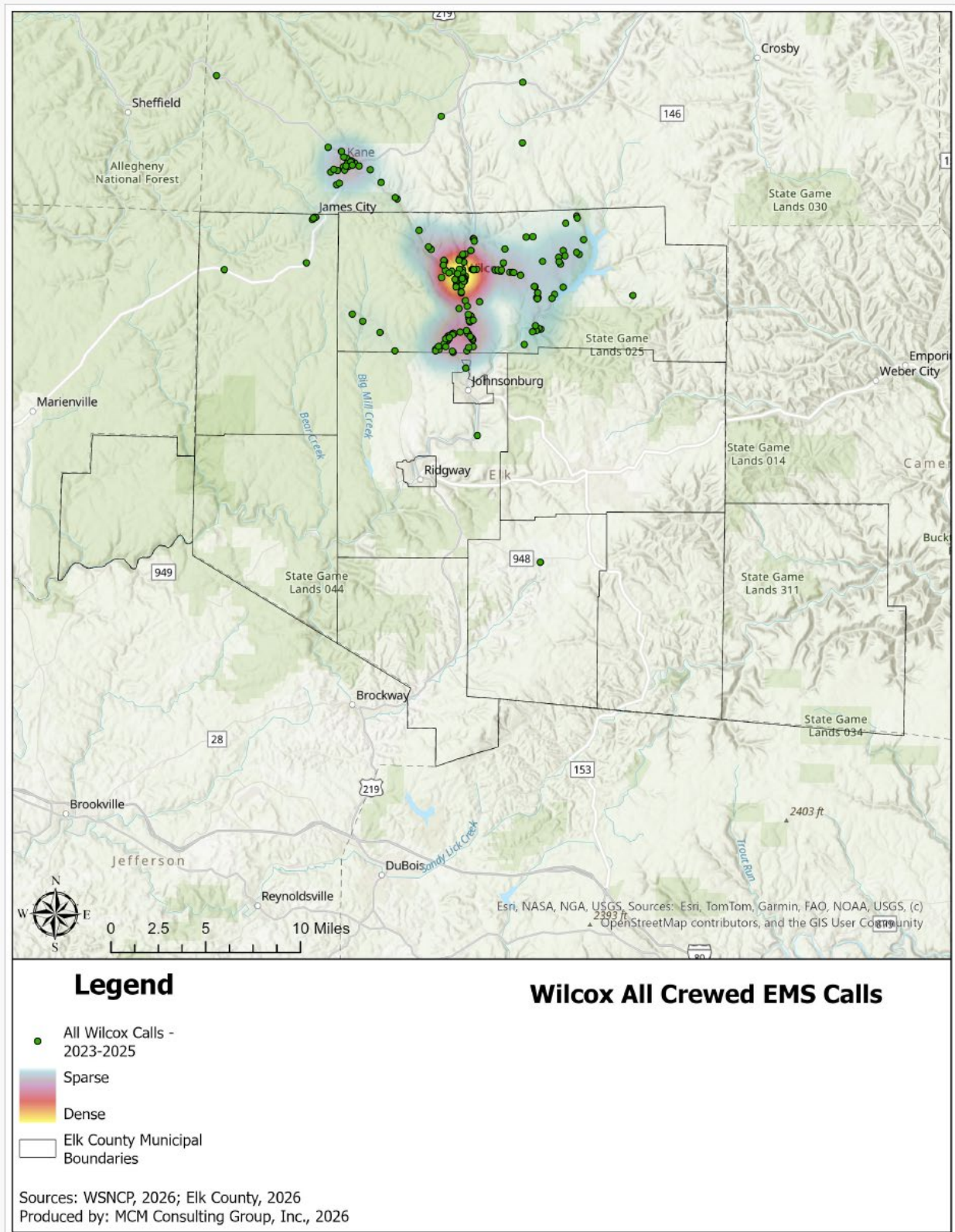
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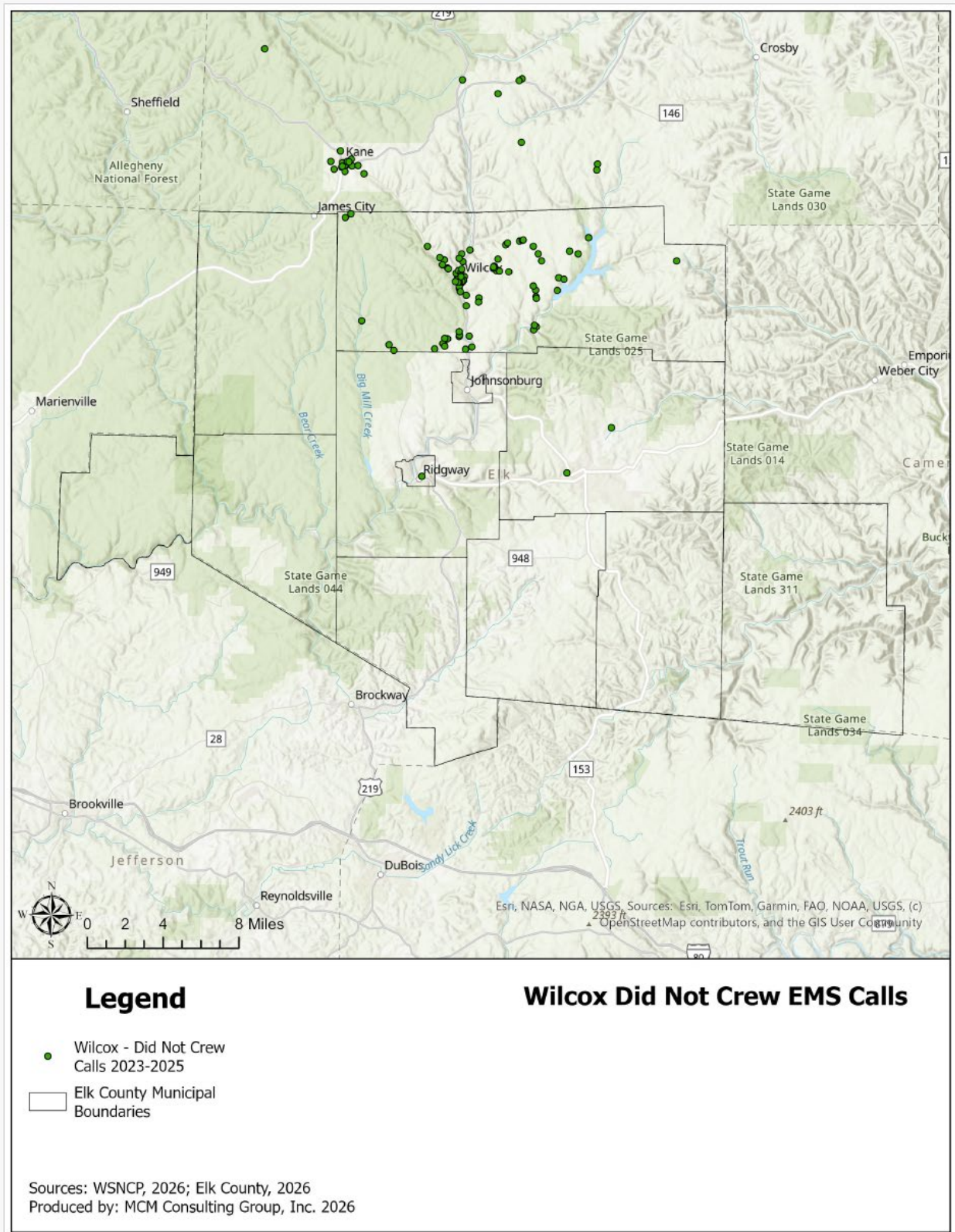
- St Marys - Did Not Crew Calls 2023-2025
- Elk County Municipal Boundaries

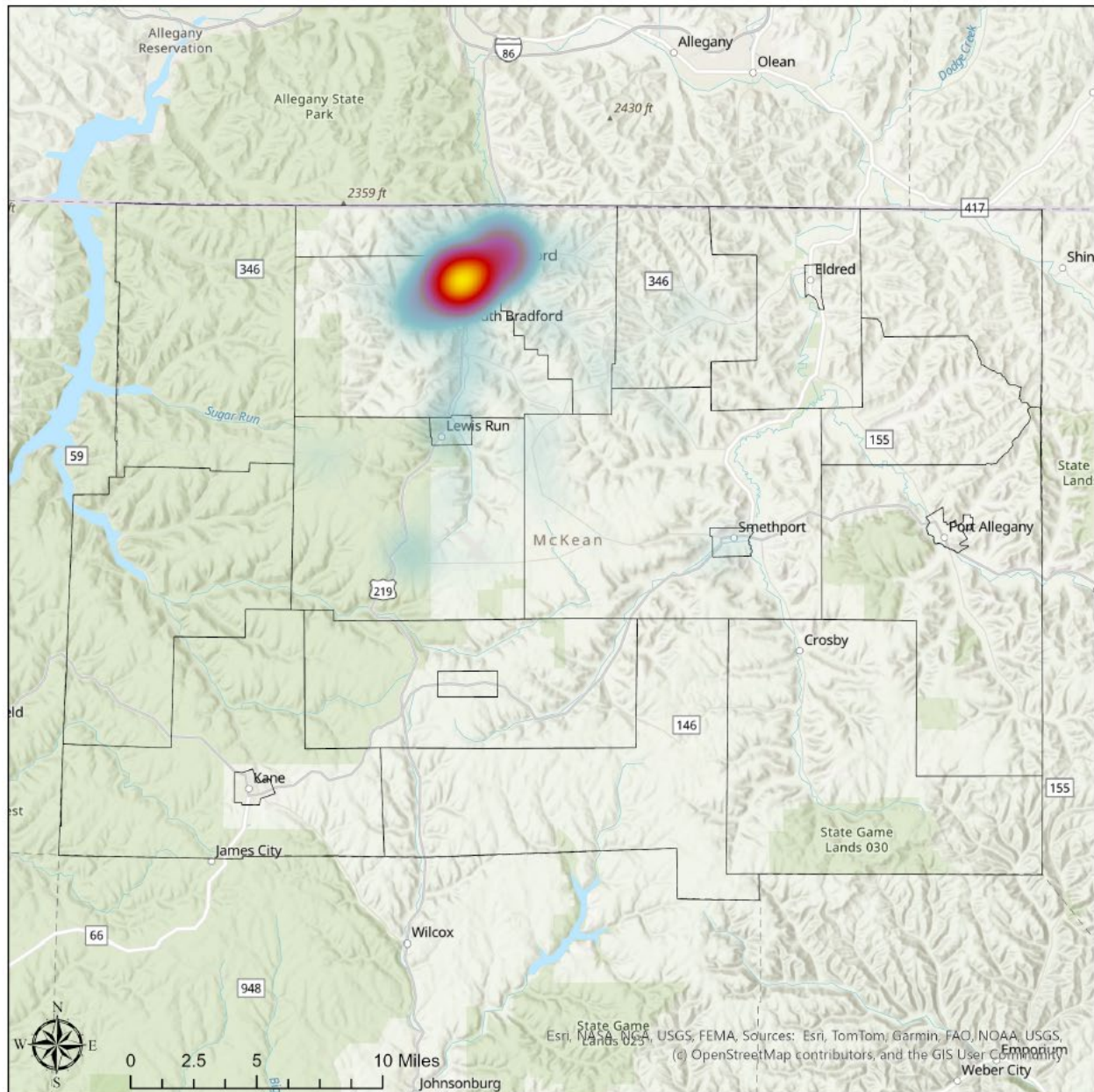
St Marys Did Not Crew EMS Calls

Sources: WSNCP, 2026; Elk County, 2026
Produced by: MCM Consulting Group, Inc. 2026







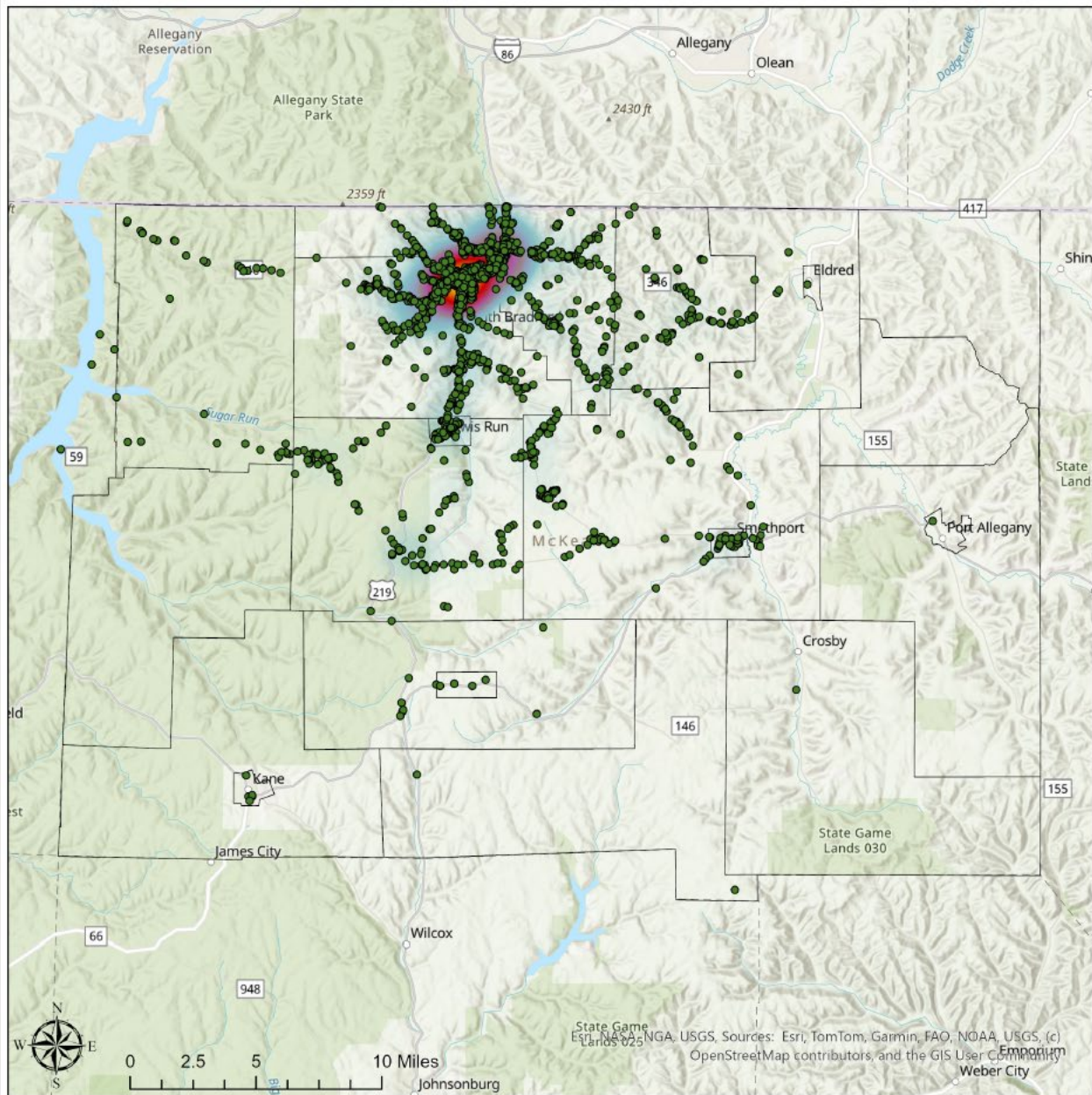


Legend

-  Sparse
-  Dense
-  McKean County
Municipal Boundaries

City of Bradford All Crewed EMS Calls

Sources: WSNCP, 2026; McKean County, 2026
Produced by: MCM Consulting Group, Inc., 2026

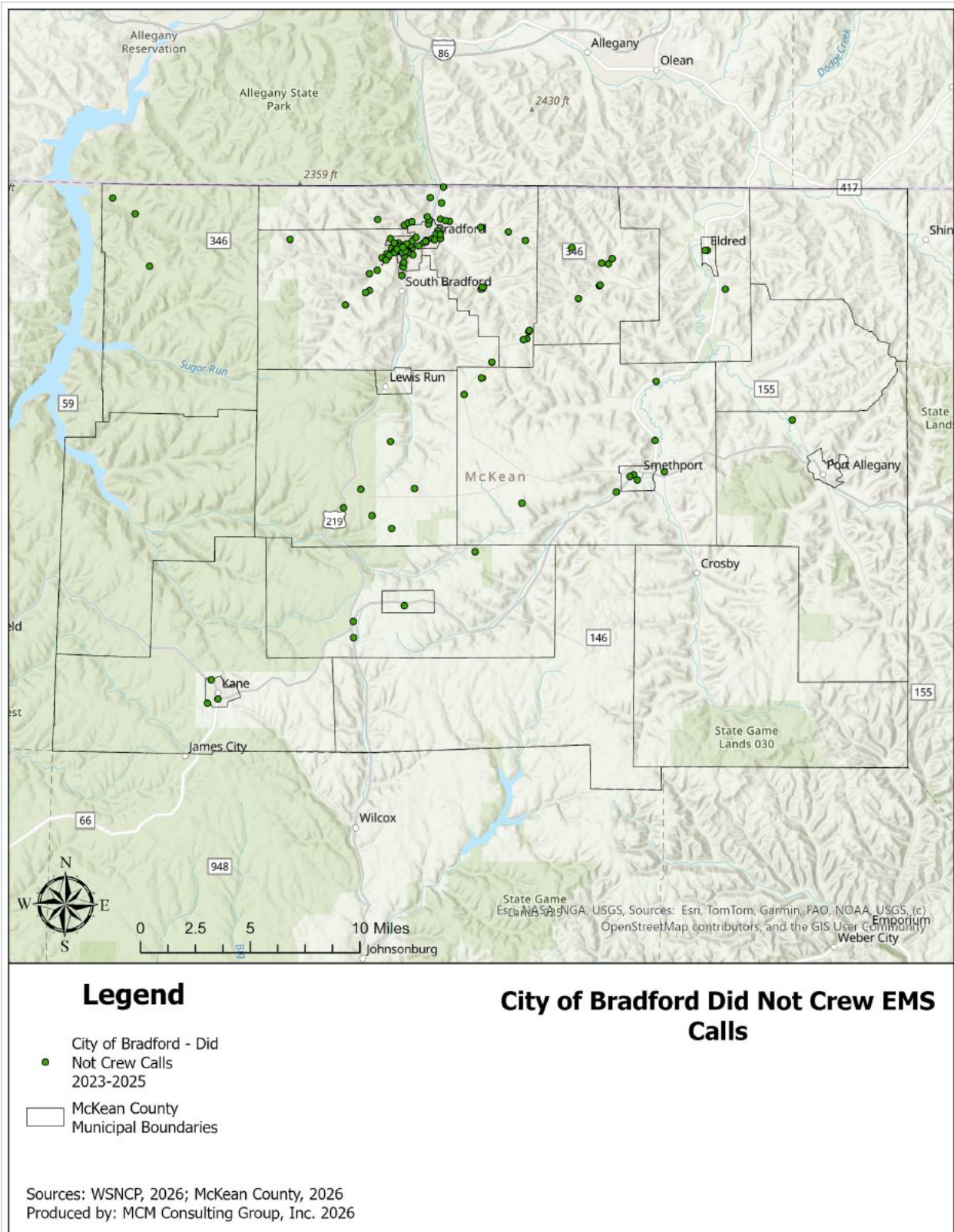


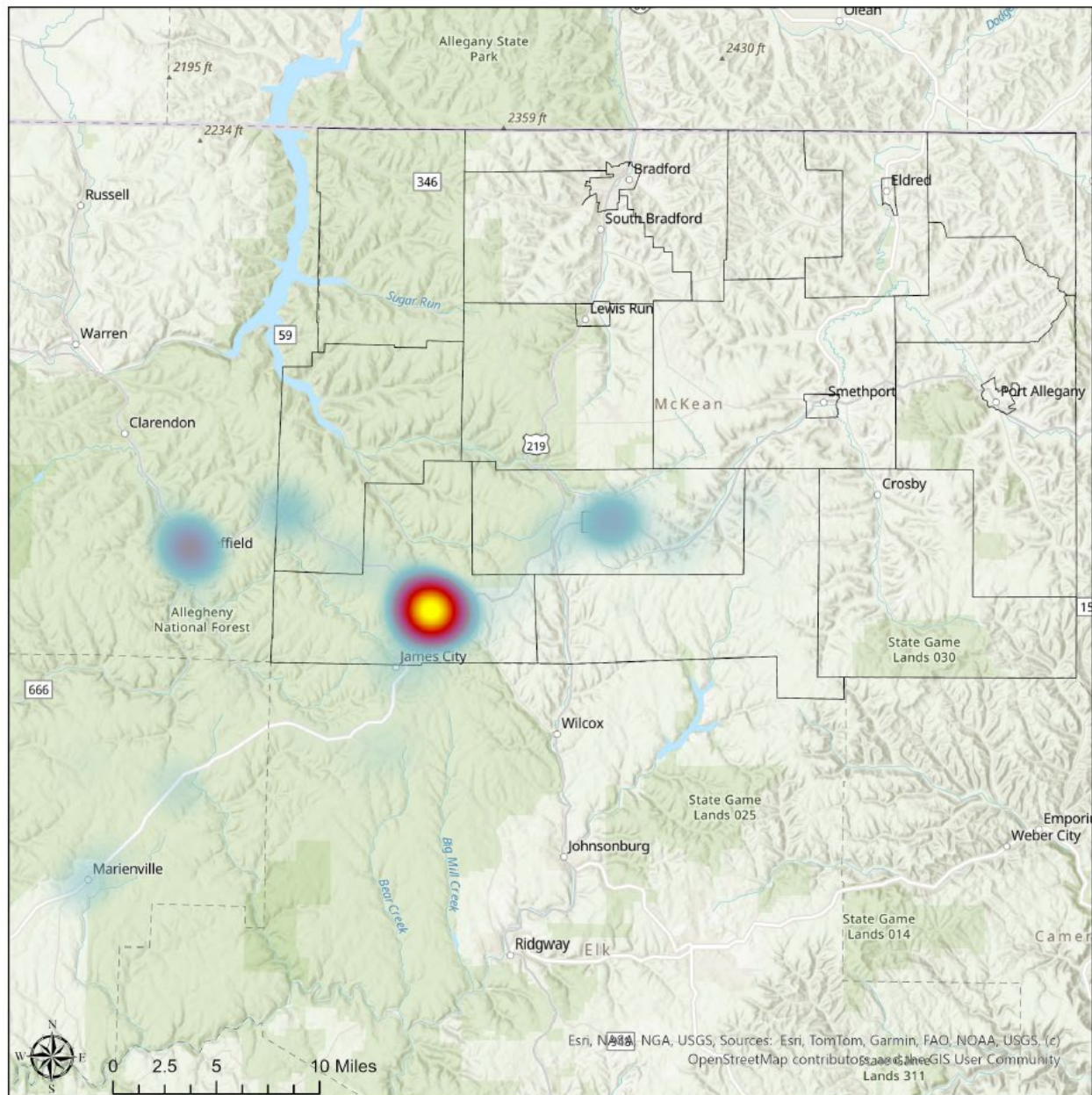
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- All City of Bradford Calls - 2023-2025
- ▭ McKean County Municipal Boundaries
- Sparse
- Dense

City of Bradford All Crewed EMS Calls

Sources: WSNCP, 2026; McKean County, 2026
Produced by: MCM Consulting Group, Inc., 2026



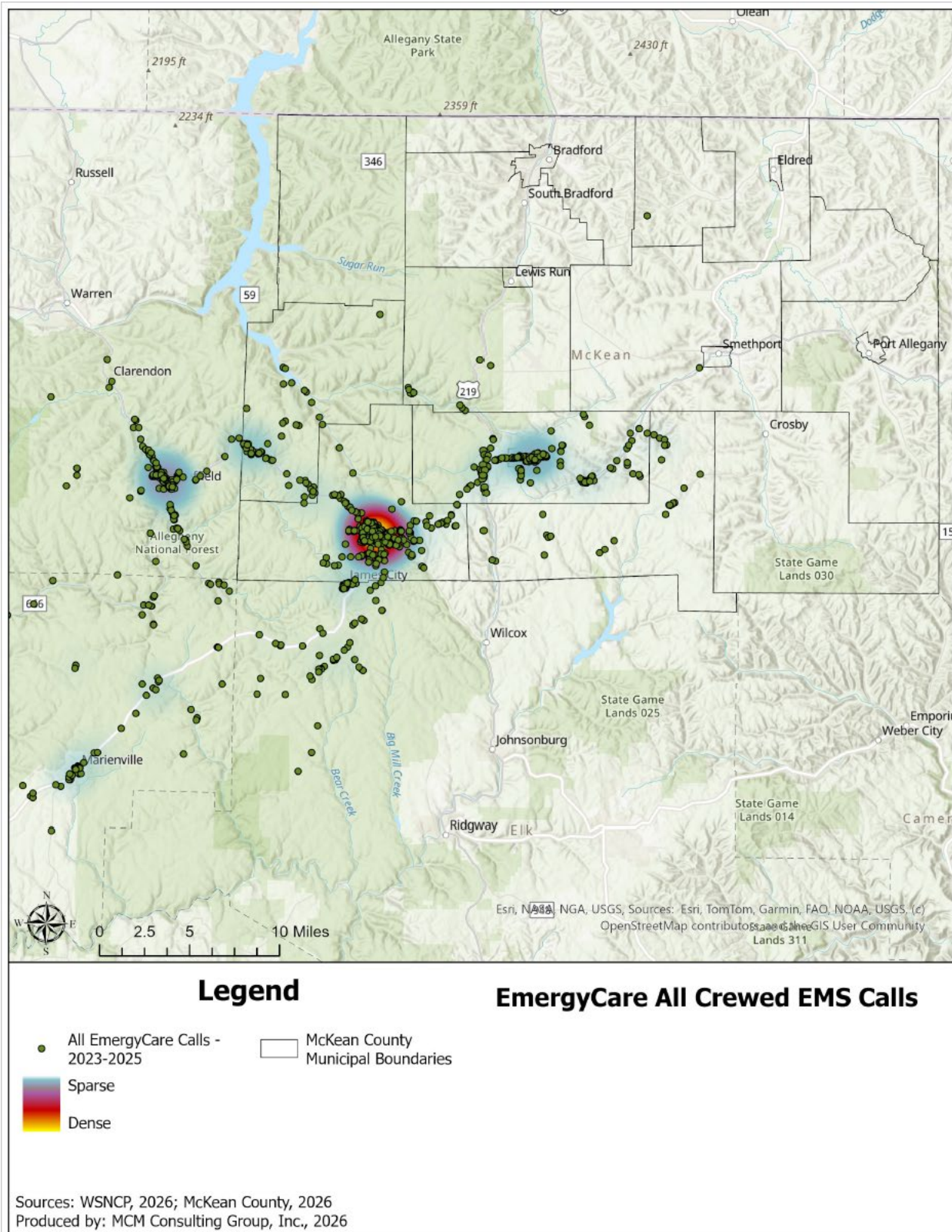


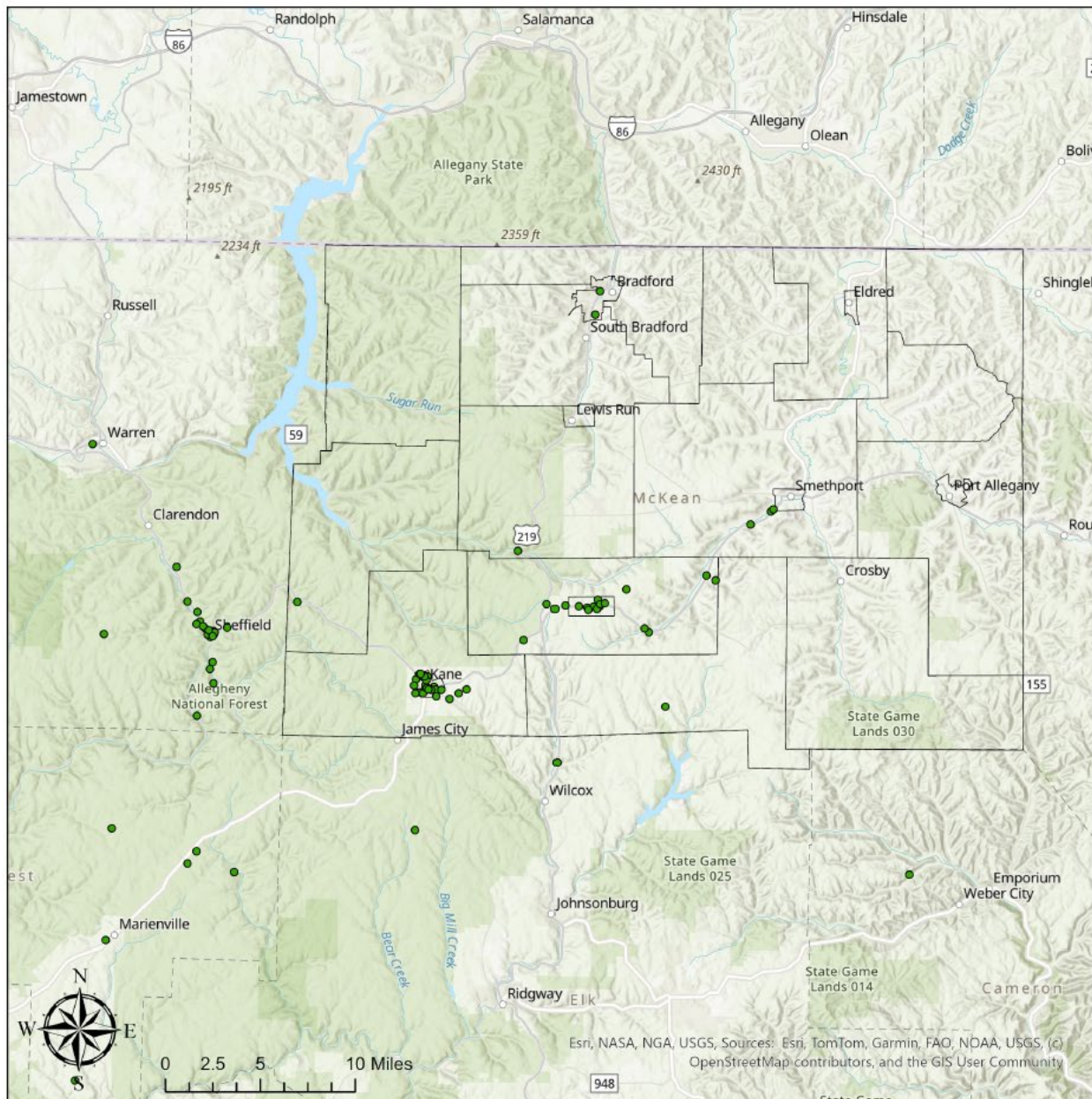
Legend

-  Sparse
-  Dense
-  McKean County Municipal Boundaries

EmergencyCare All Crewed EMS Calls

Sources: WSNCP, 2026; McKean County, 2026
Produced by: MCM Consulting Group, Inc., 2026



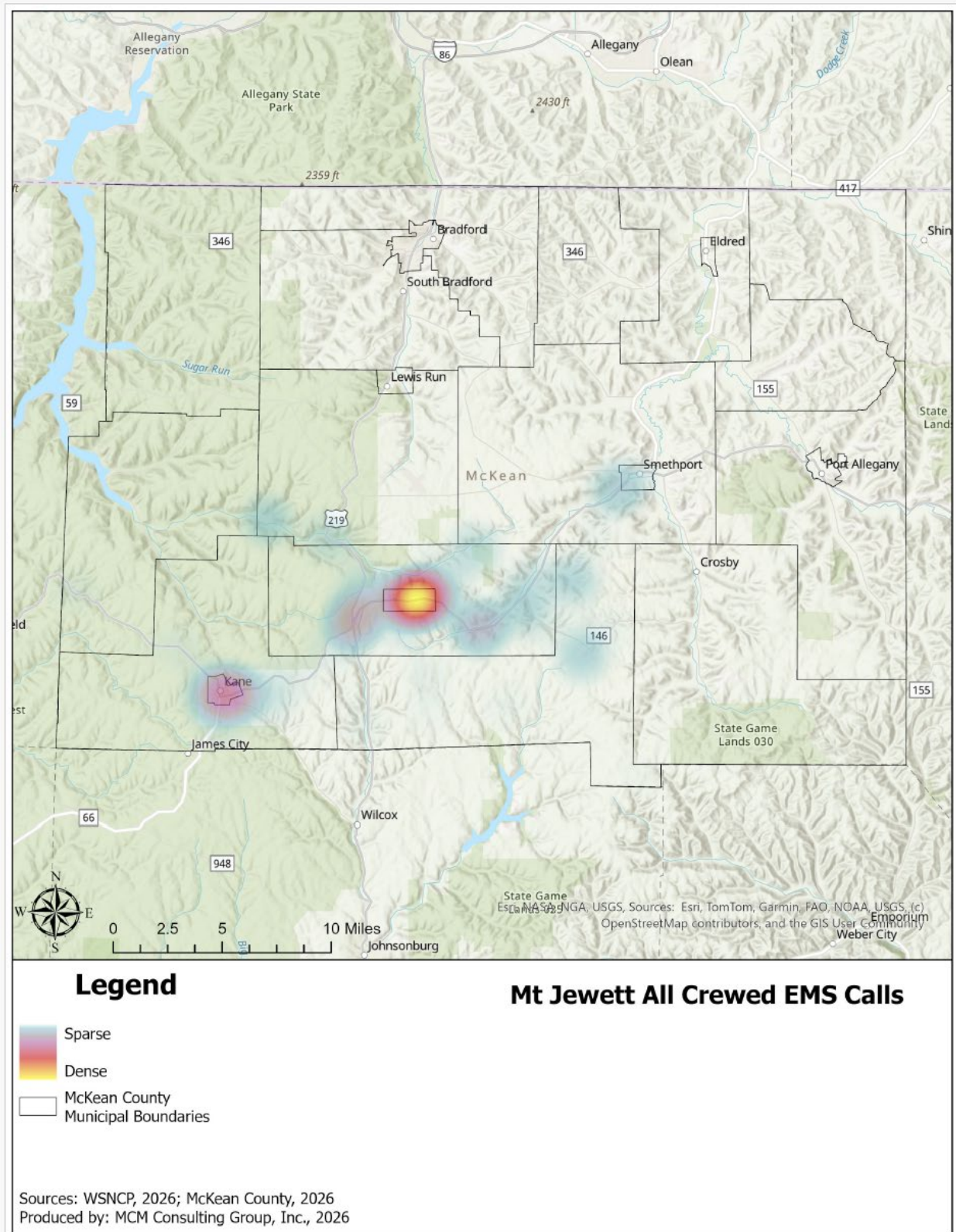


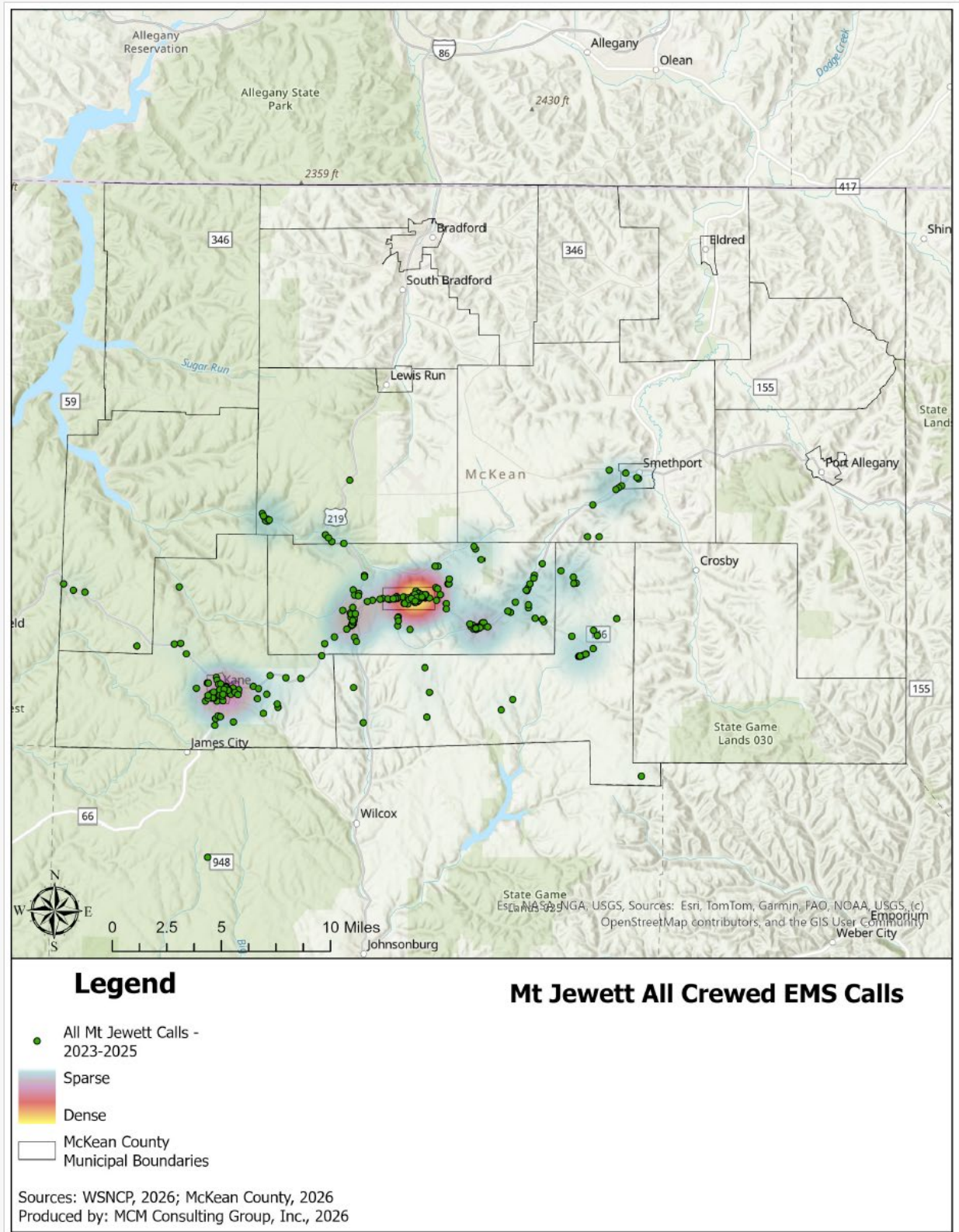
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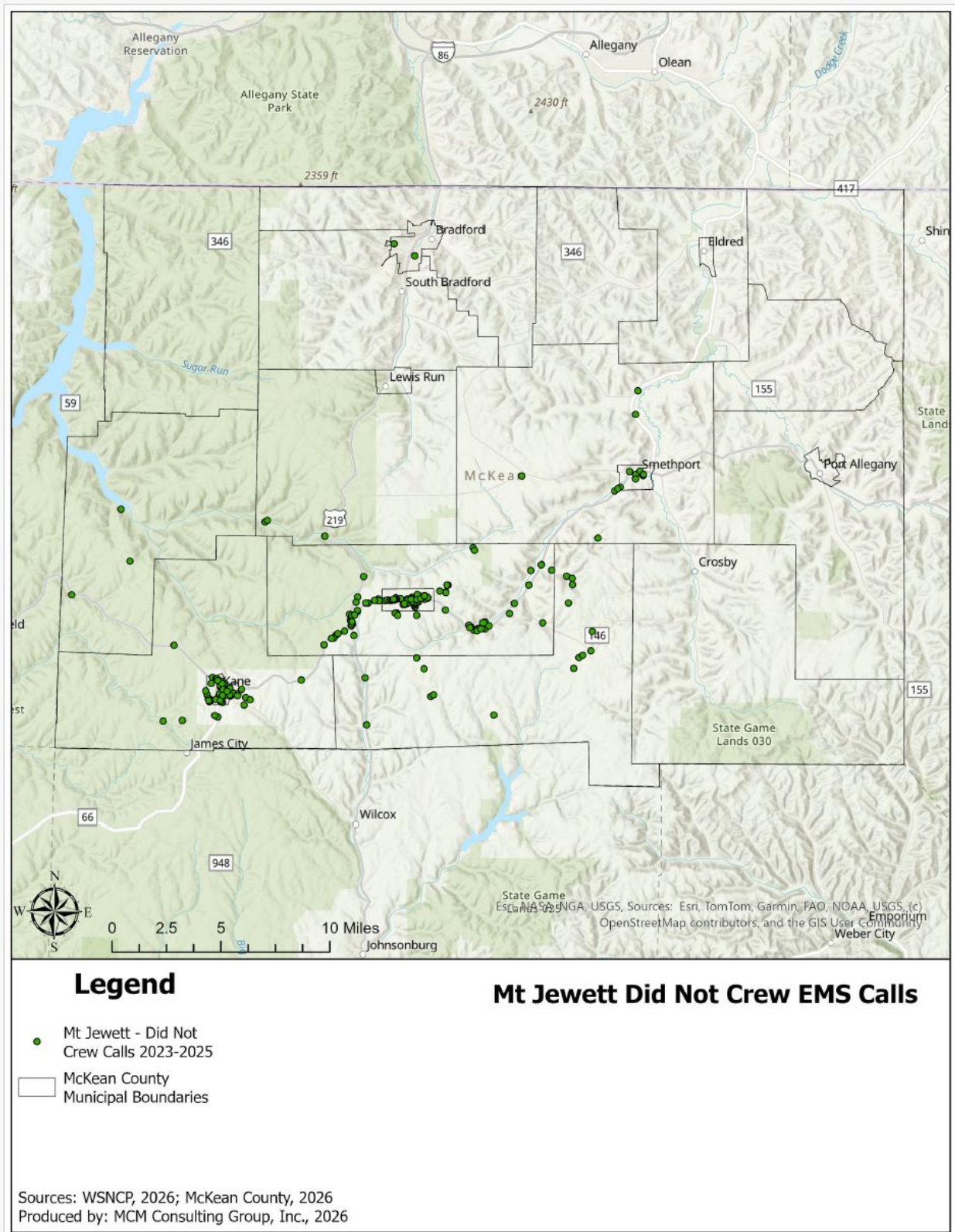
- EmergencyCare - Did Not Crew Calls 2023-2025
- ▭ McKean County Municipal Boundaries

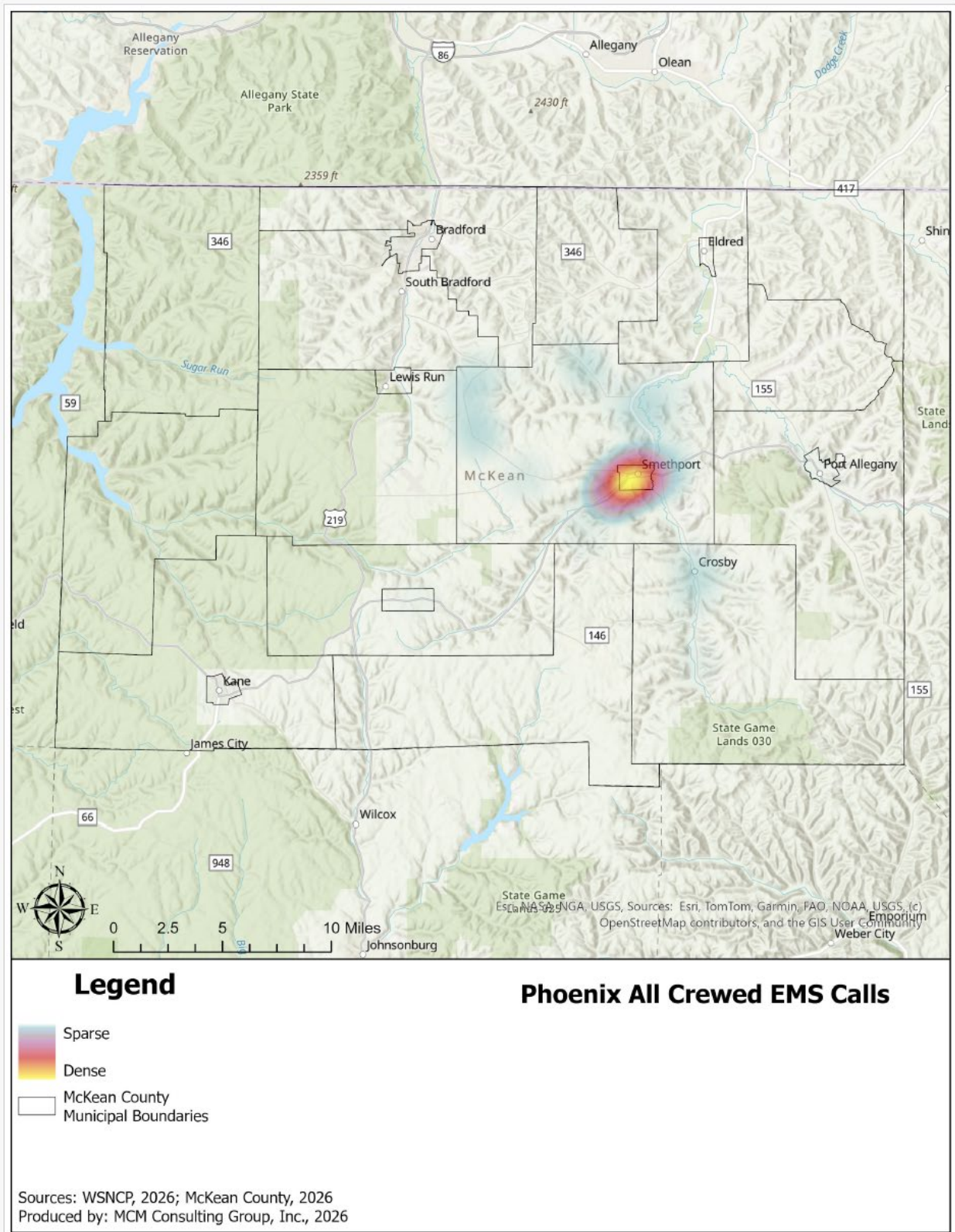
EmergencyCare Did Not Crew EMS Calls

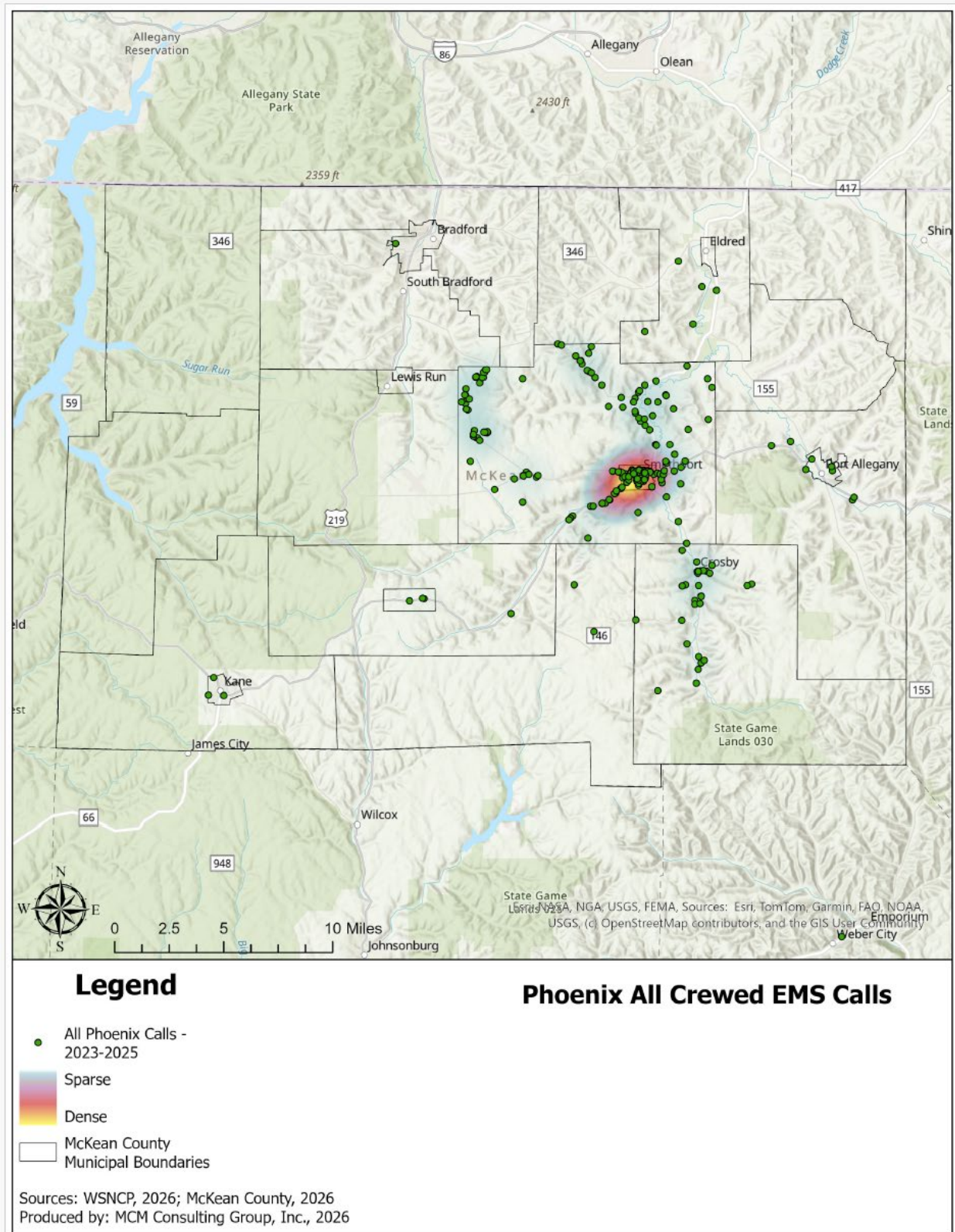
Sources: WSNCP, 2026; McKean County, 2026
Produced by: MCM Consulting Group, Inc. 2026

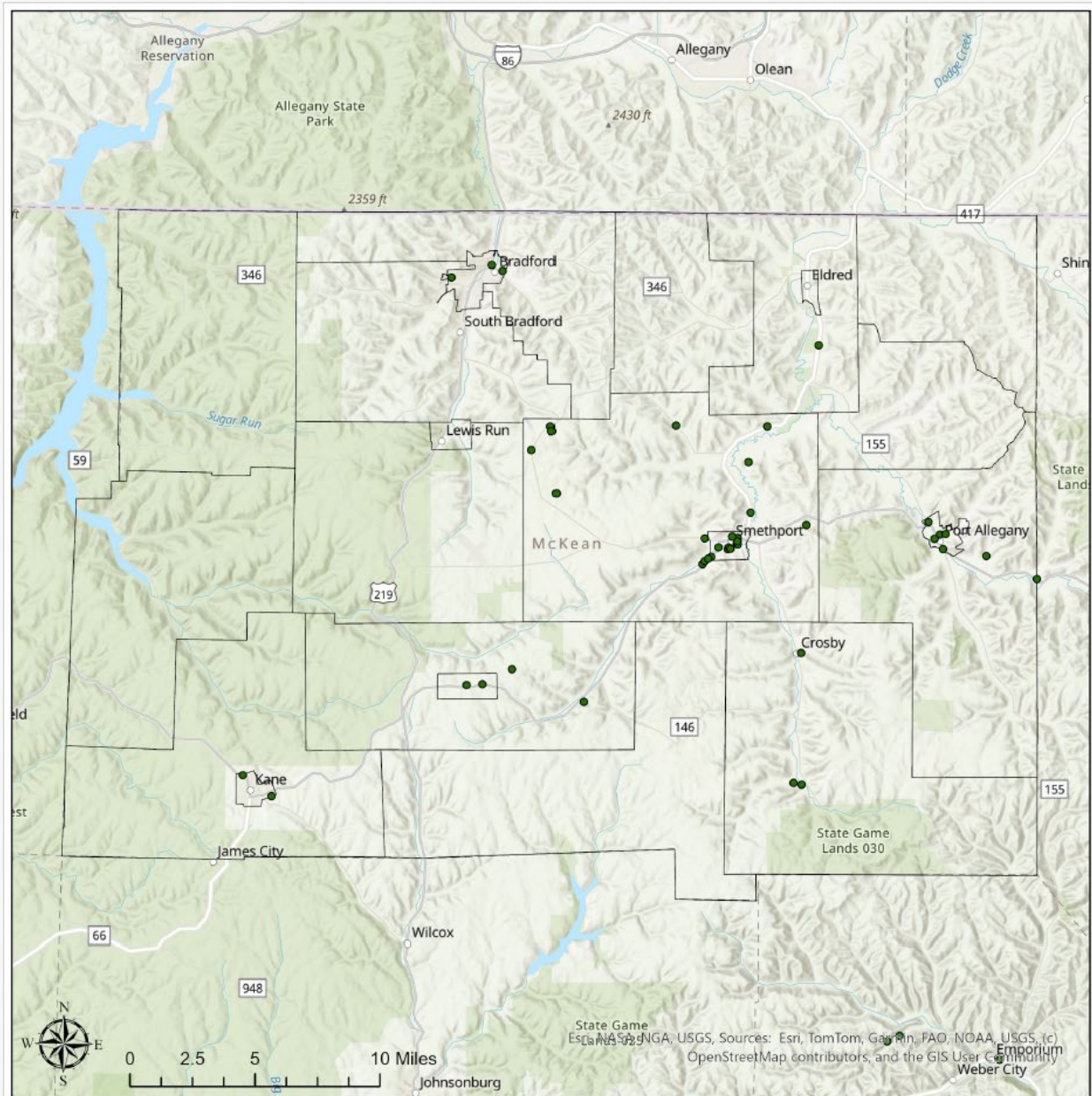










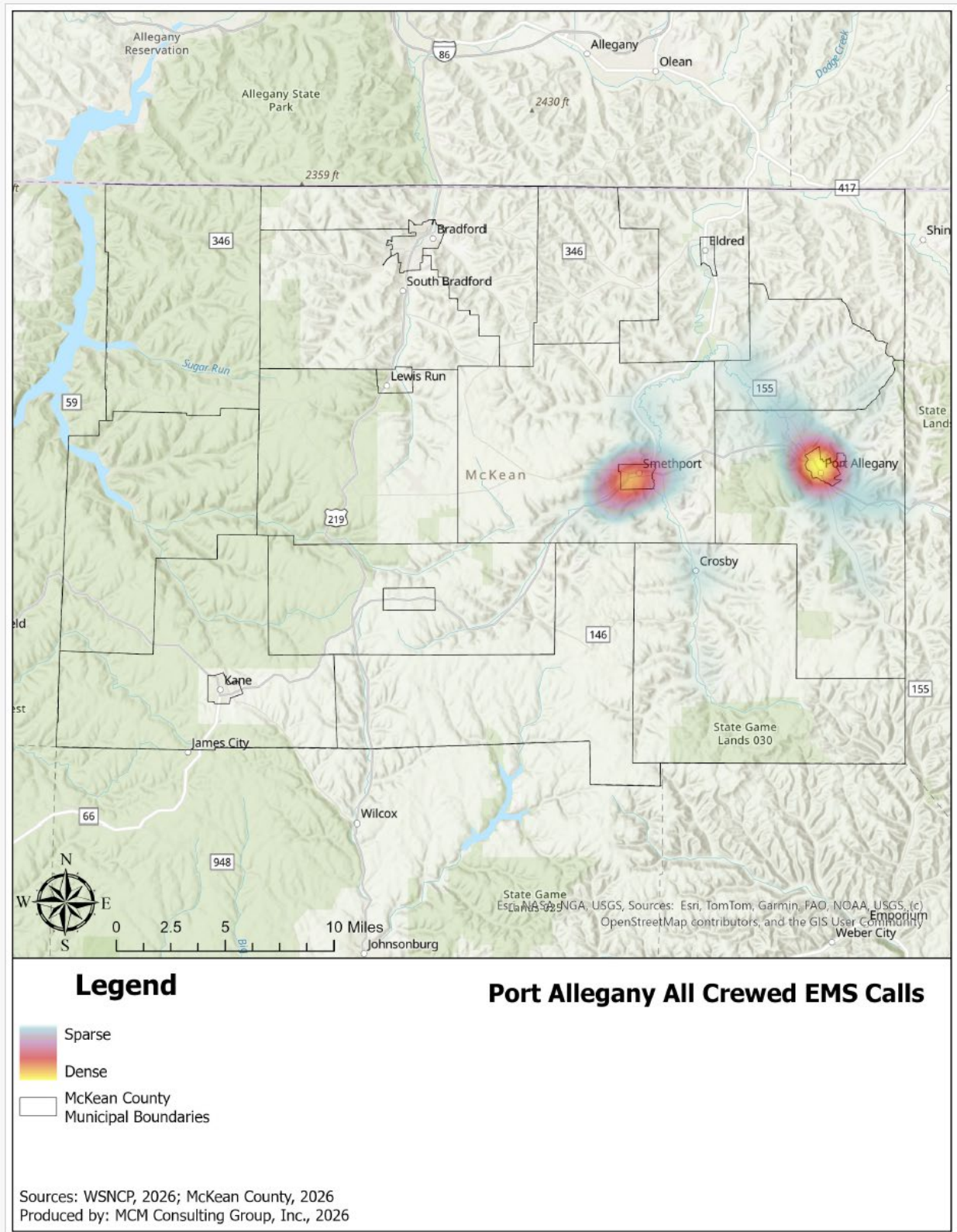


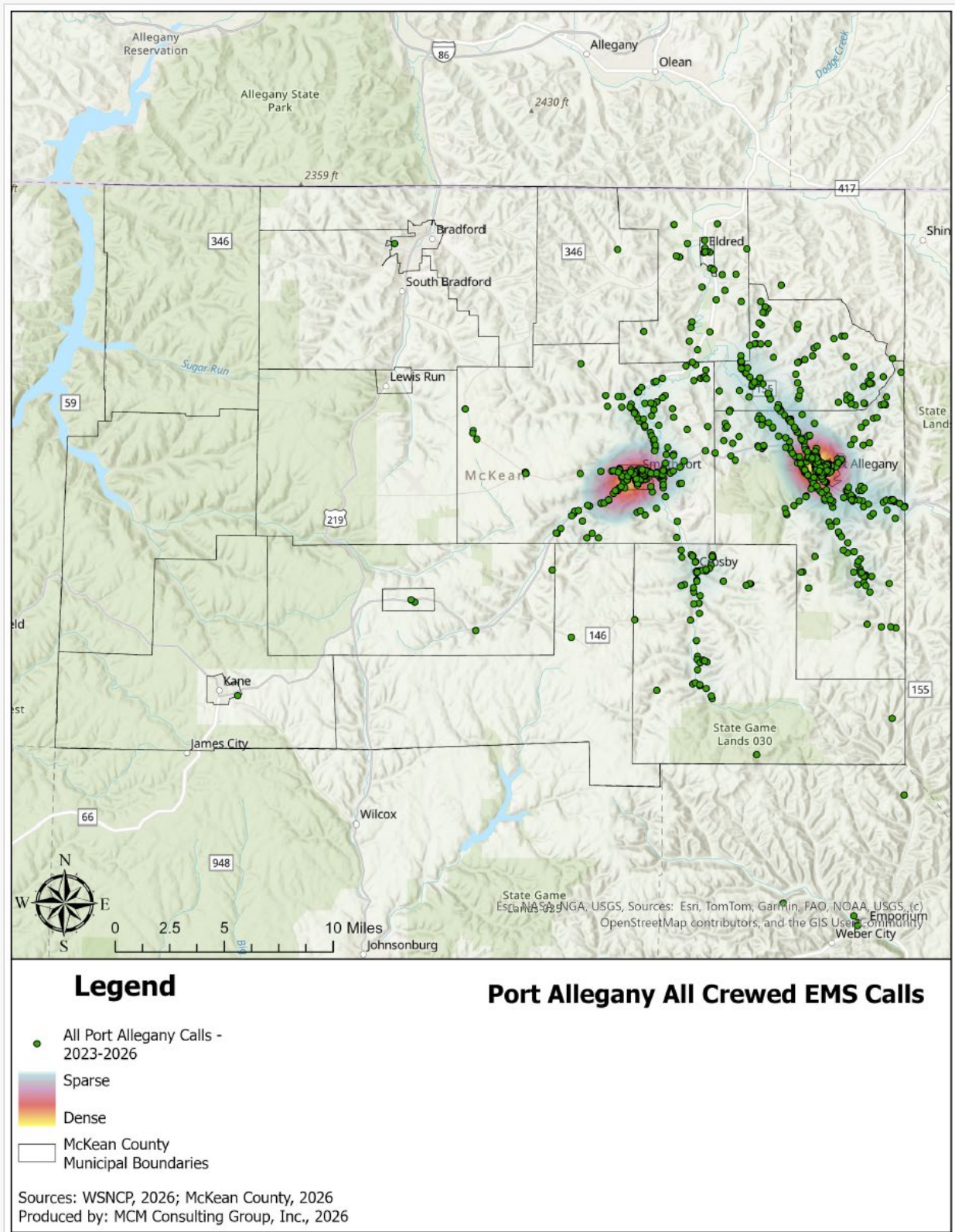
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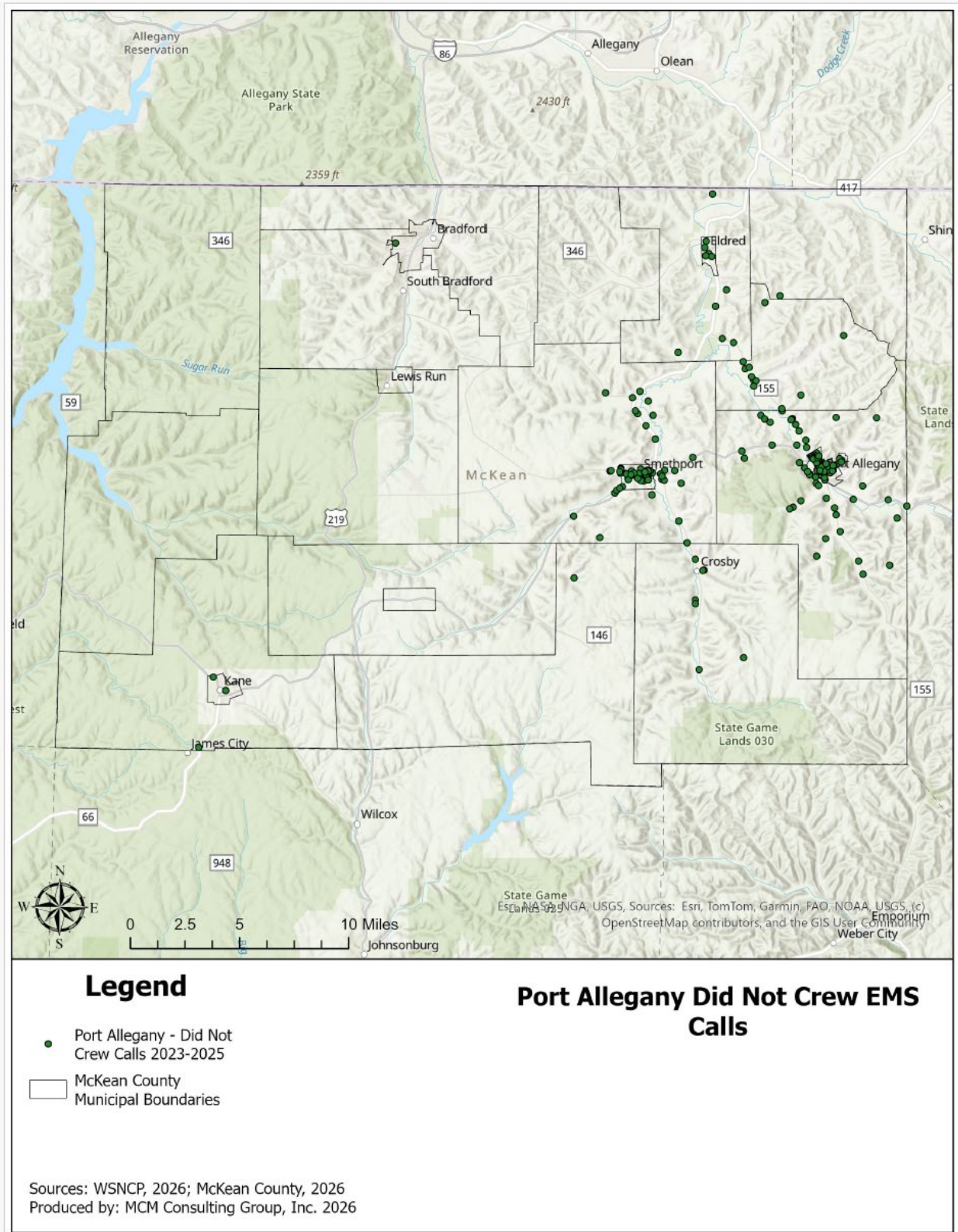
- Phoenix - Did Not Crew Calls 2023-2025
- McKean County Municipal Boundaries

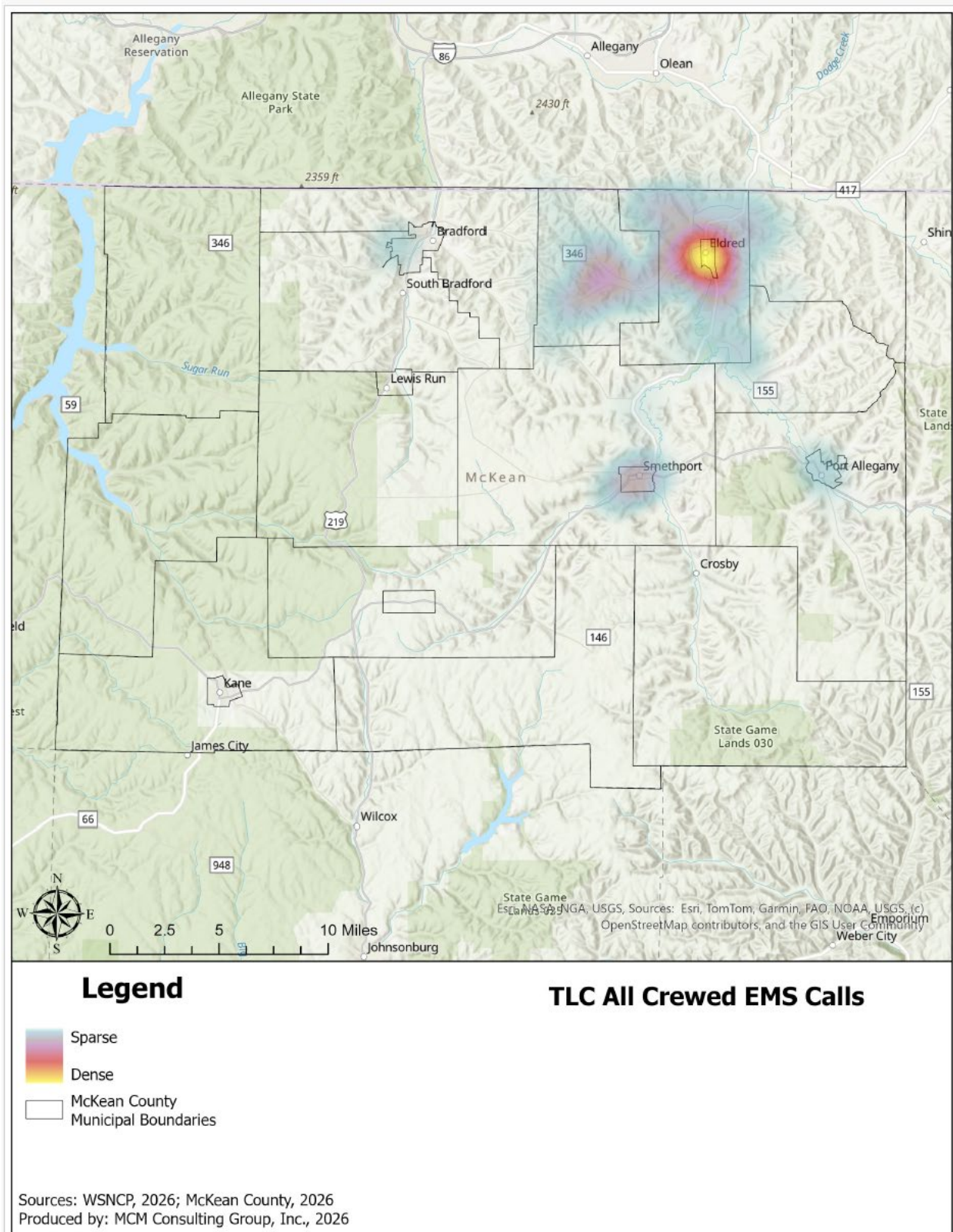
Phoenix Did Not Crew EMS Calls

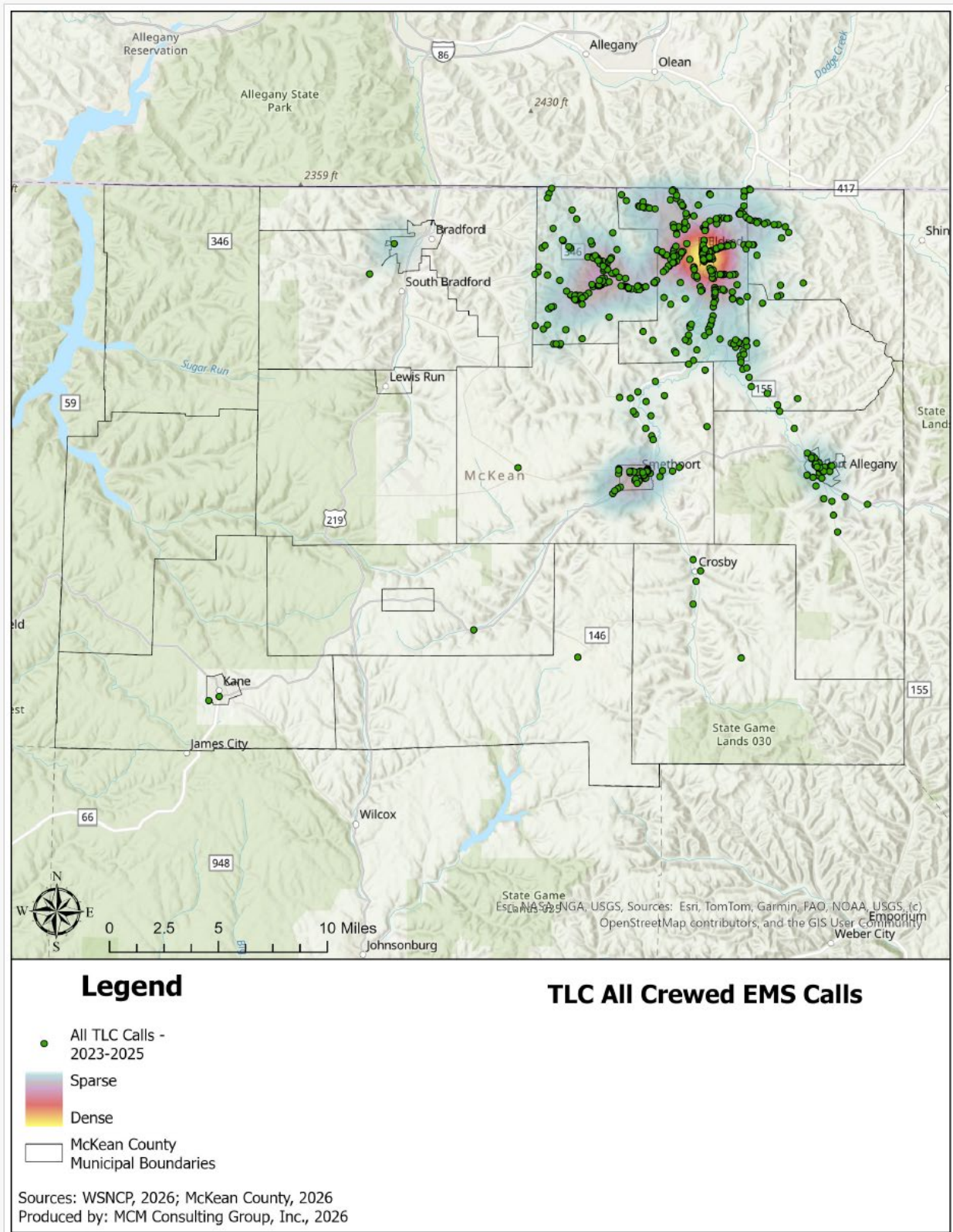
Sources: WSNCP, 2026; McKean County, 2026
Produced by: MCM Consulting Group, Inc. 2026

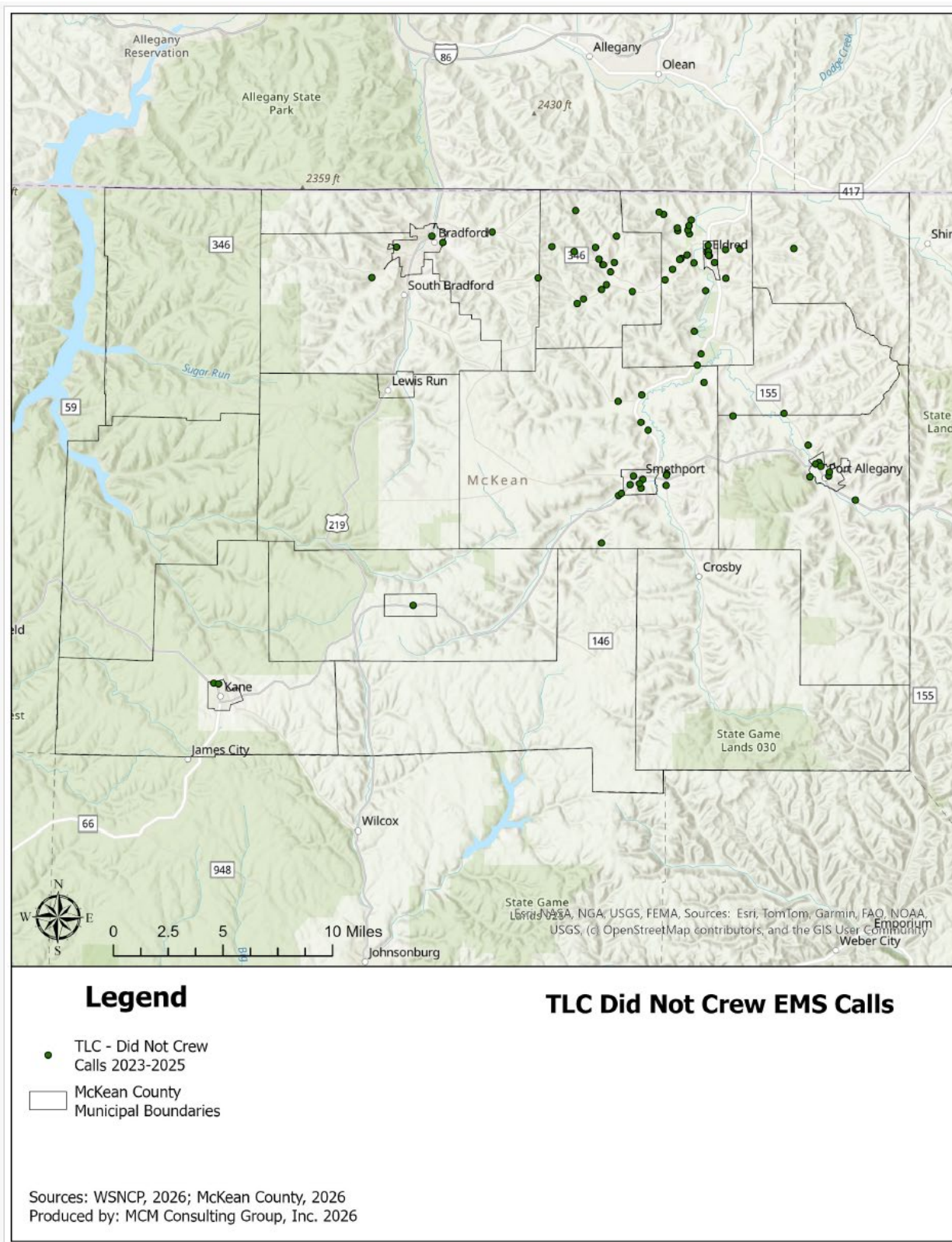


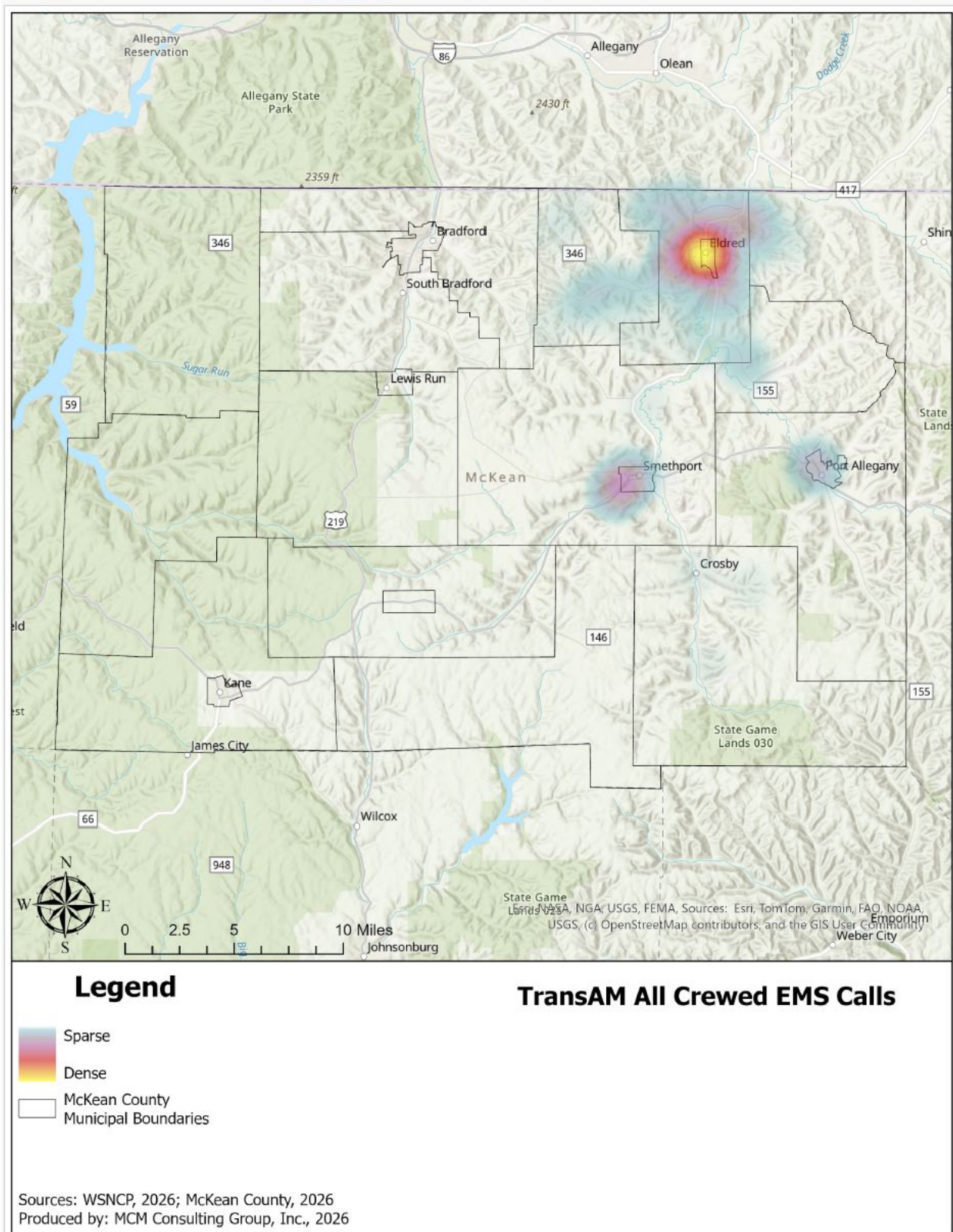


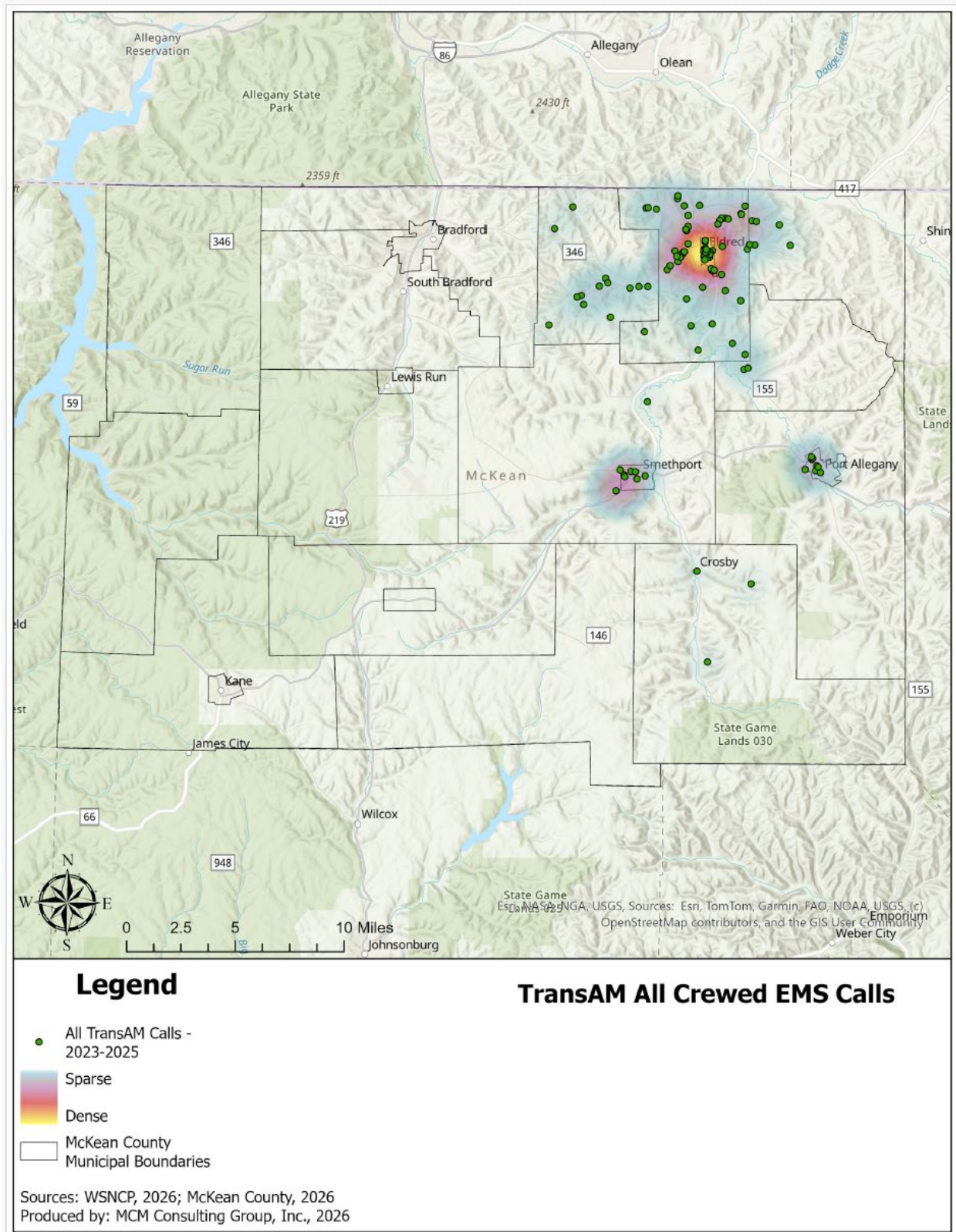


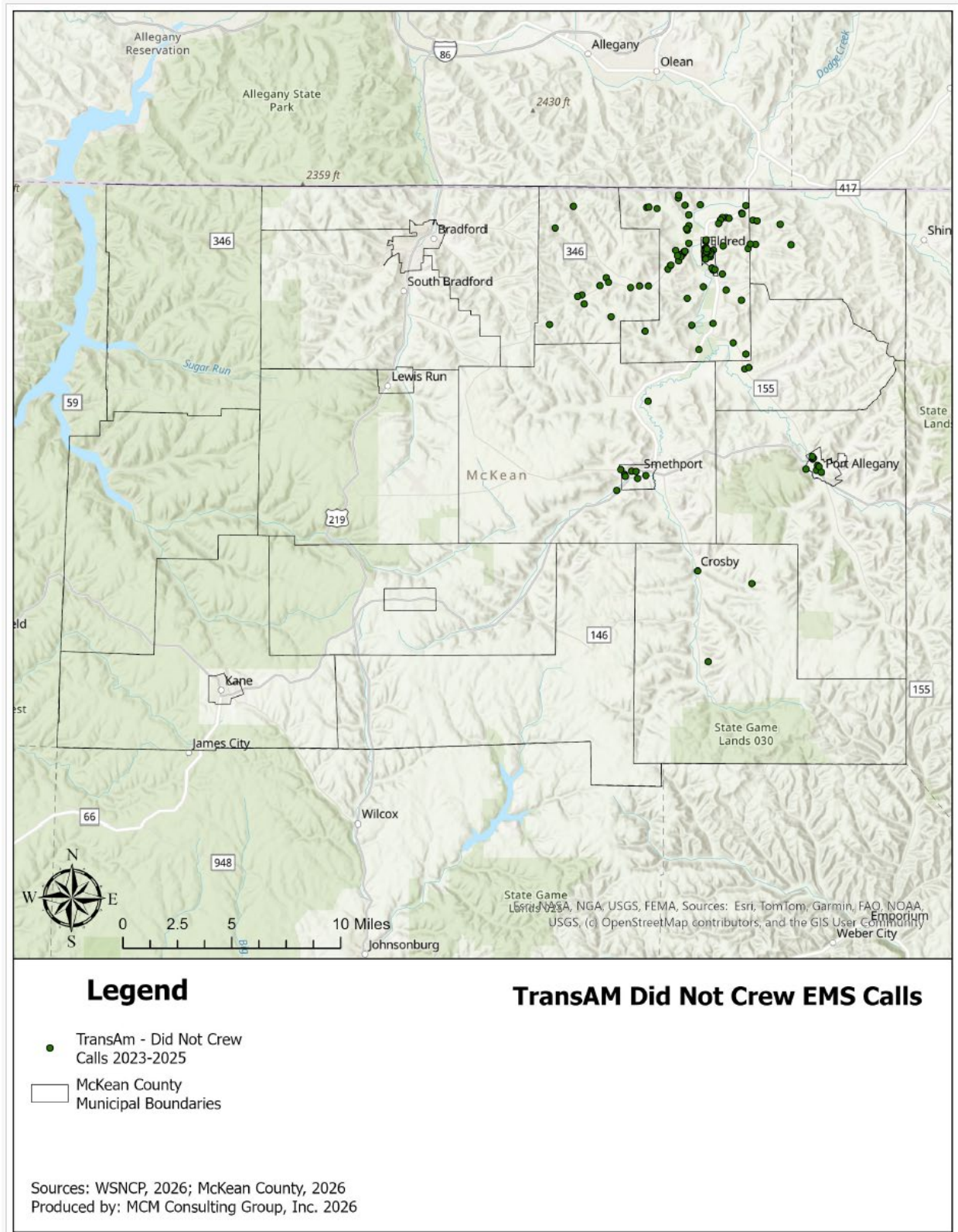


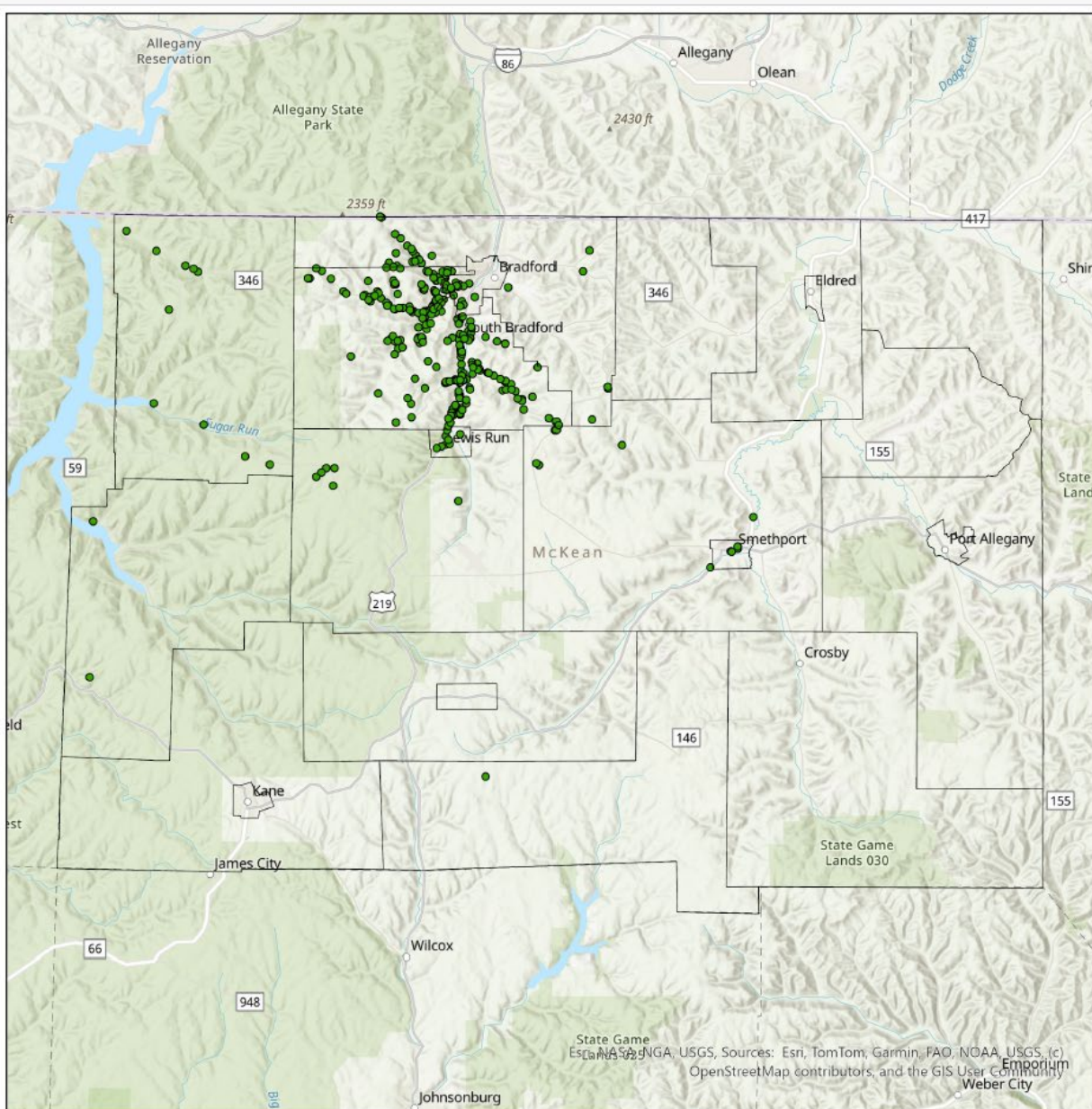










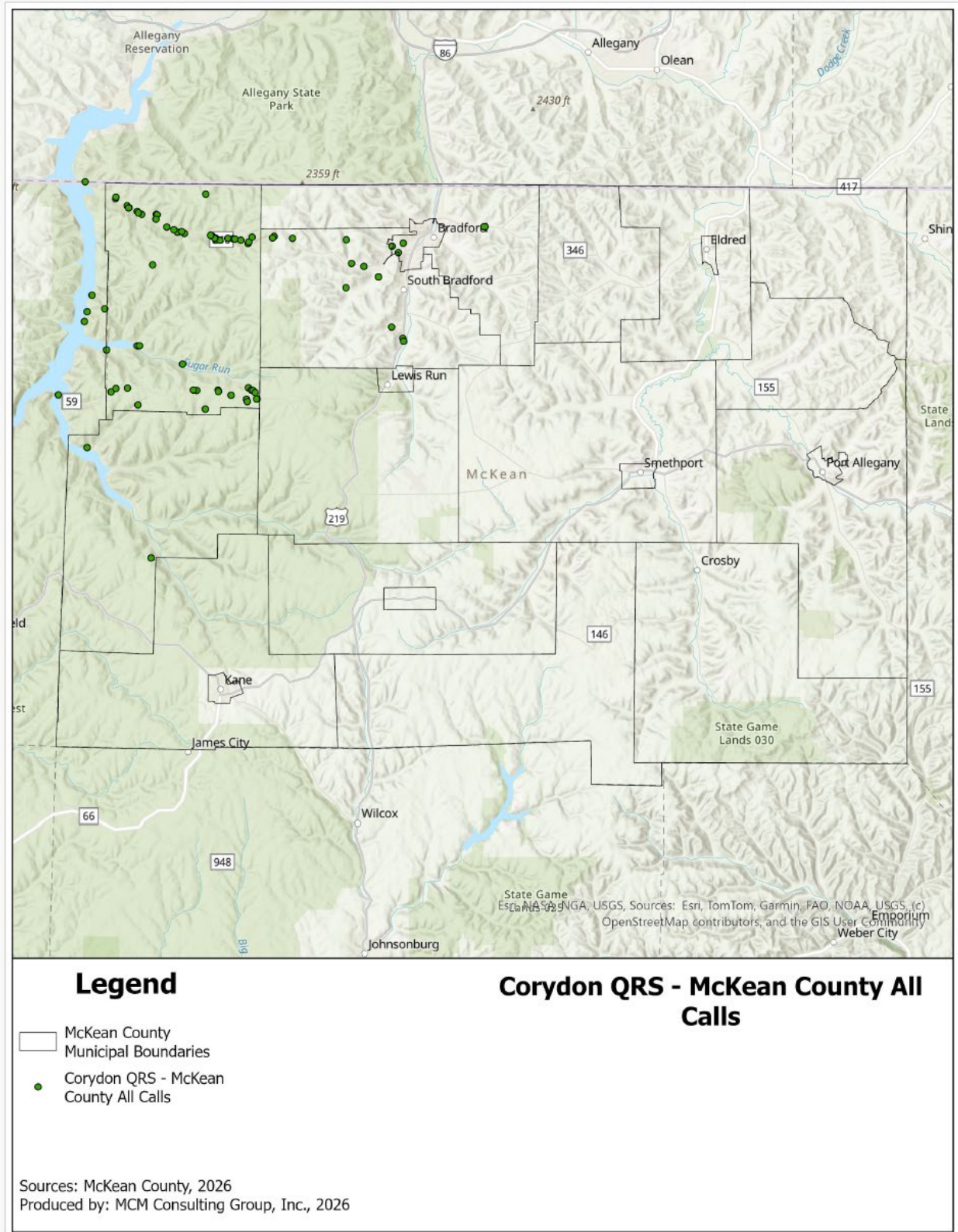


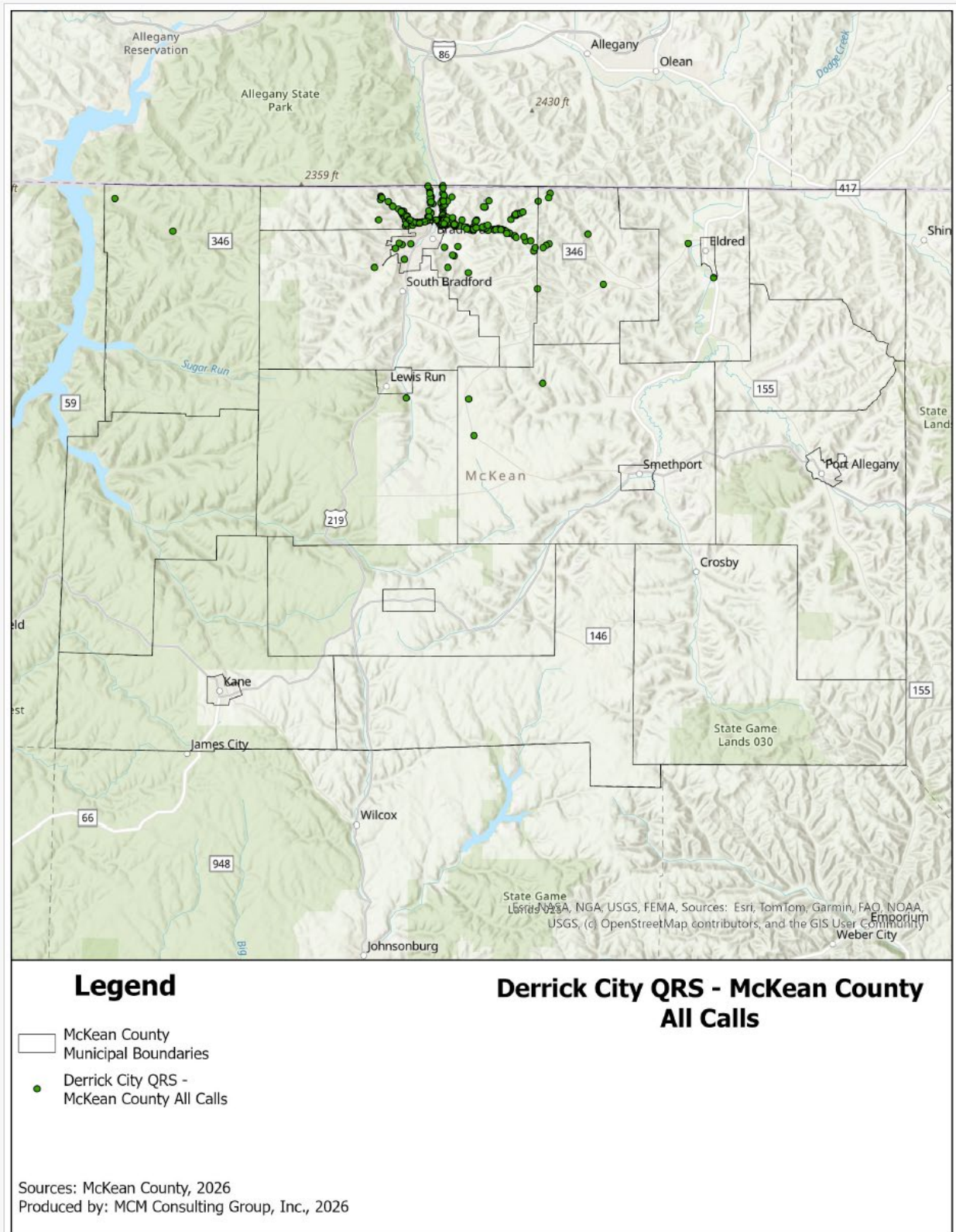
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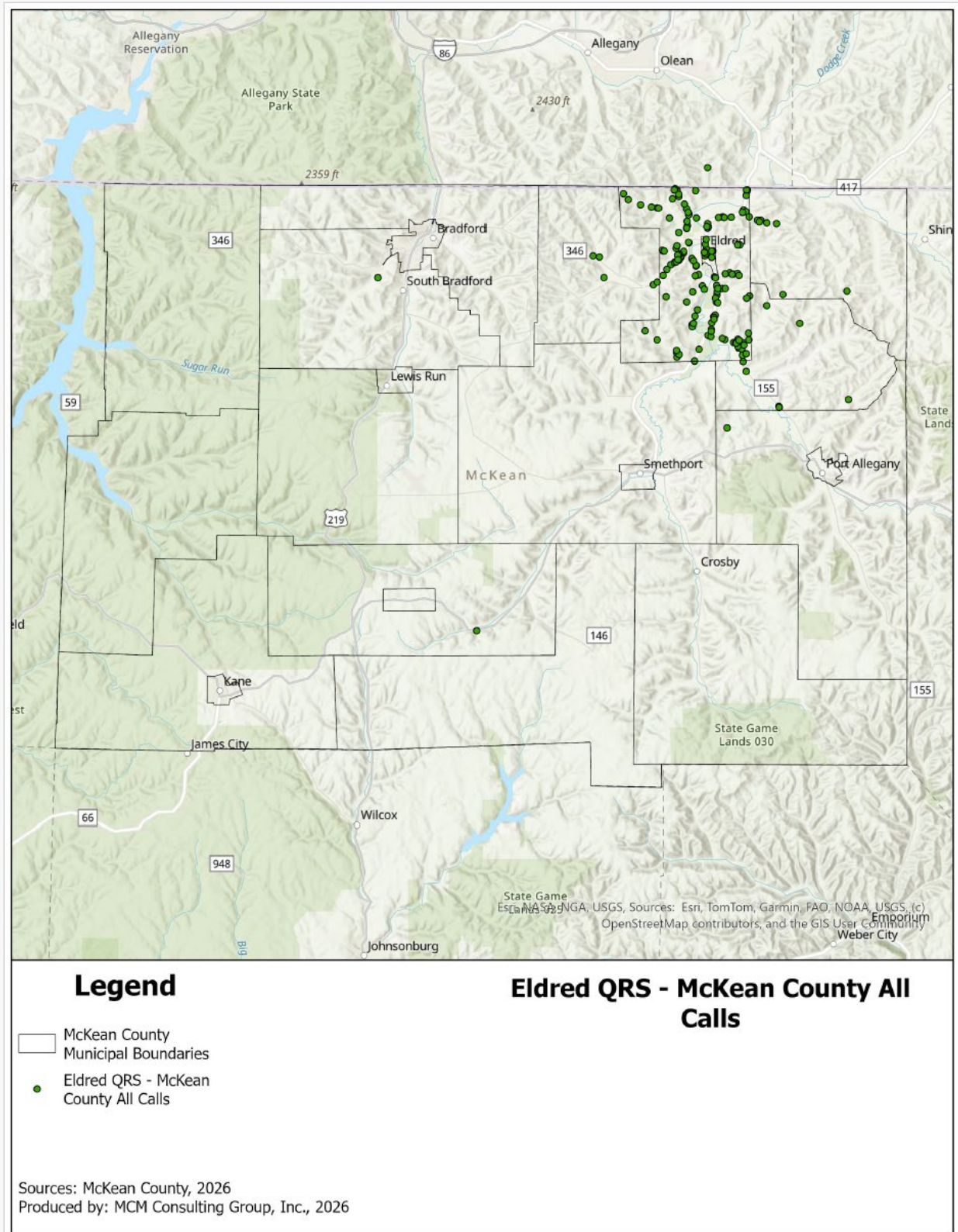
-  McKean County
-  Municipal Boundaries
-  Bradford QRS - McKean County All Calls

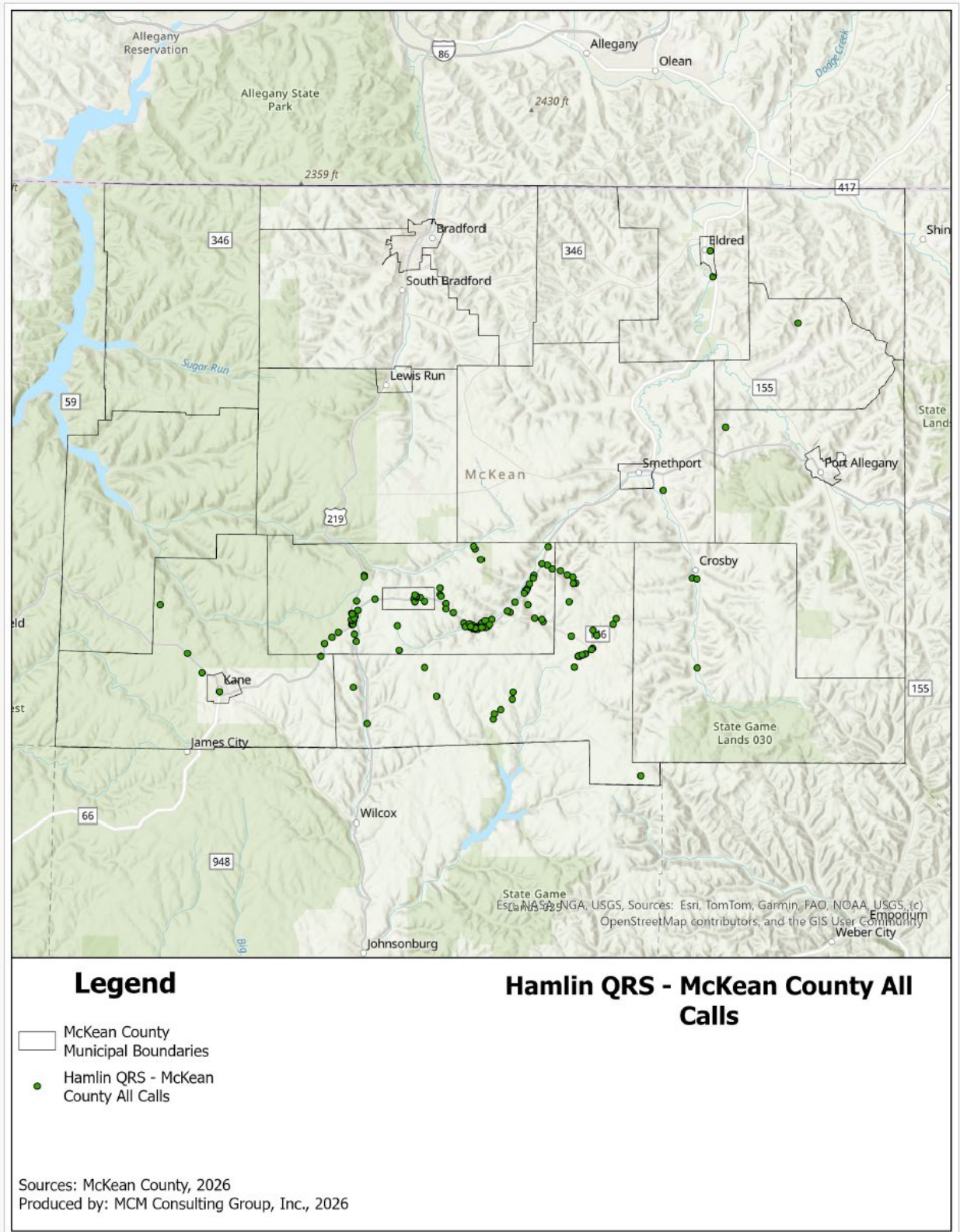
Bradford QRS - McKean County All Calls

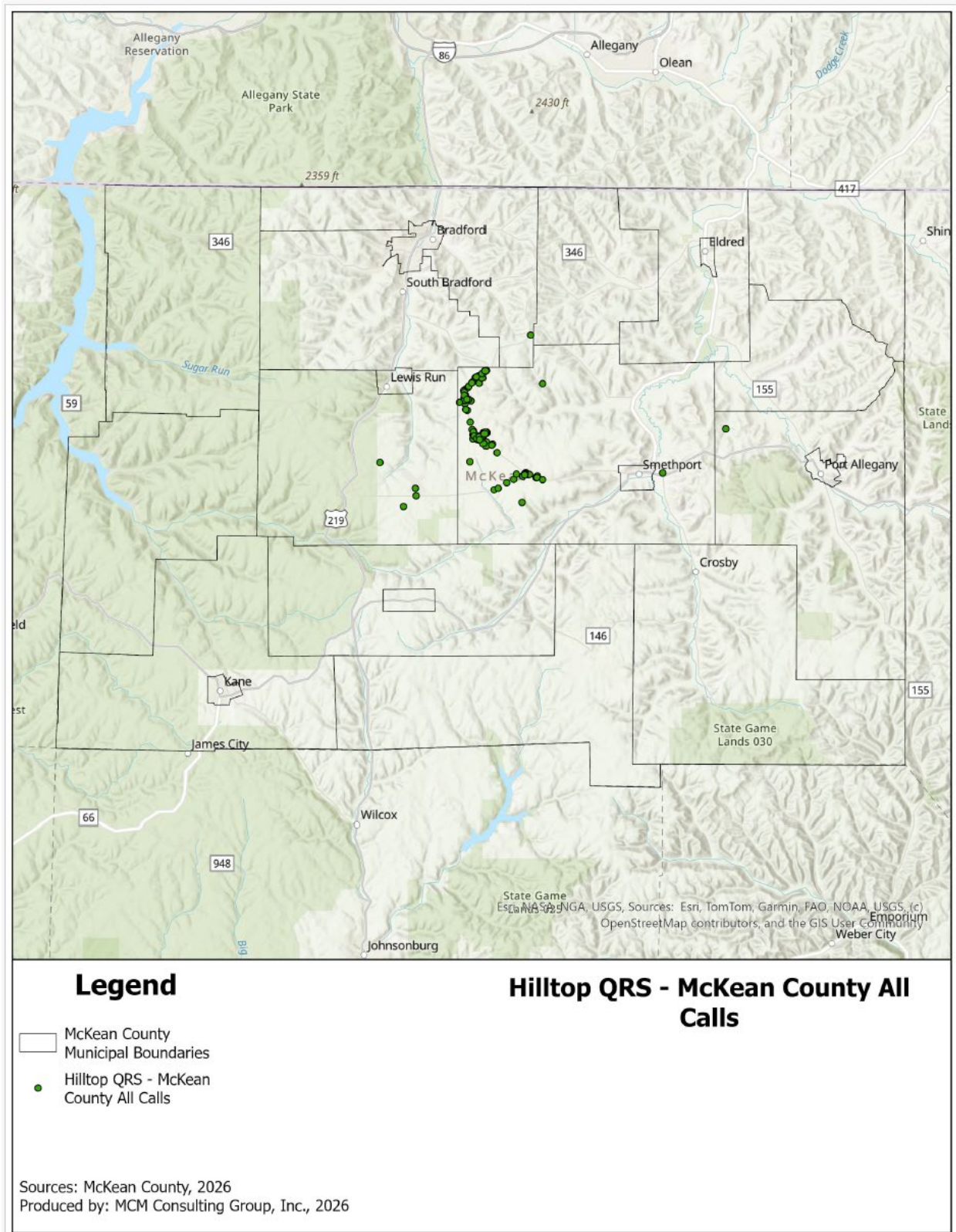
Sources: McKean County, 2026
Produced by: MCM Consulting Group, Inc., 2026

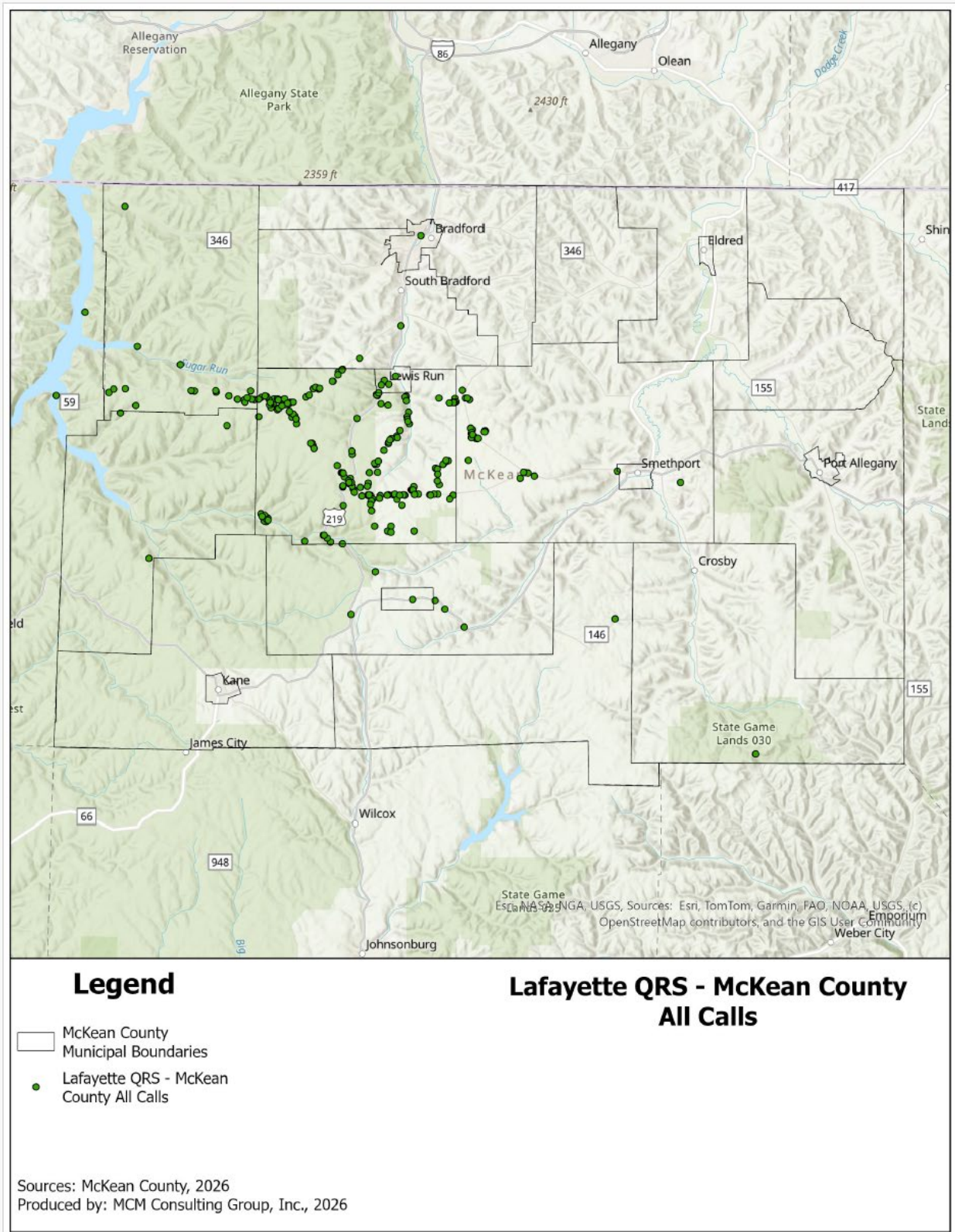


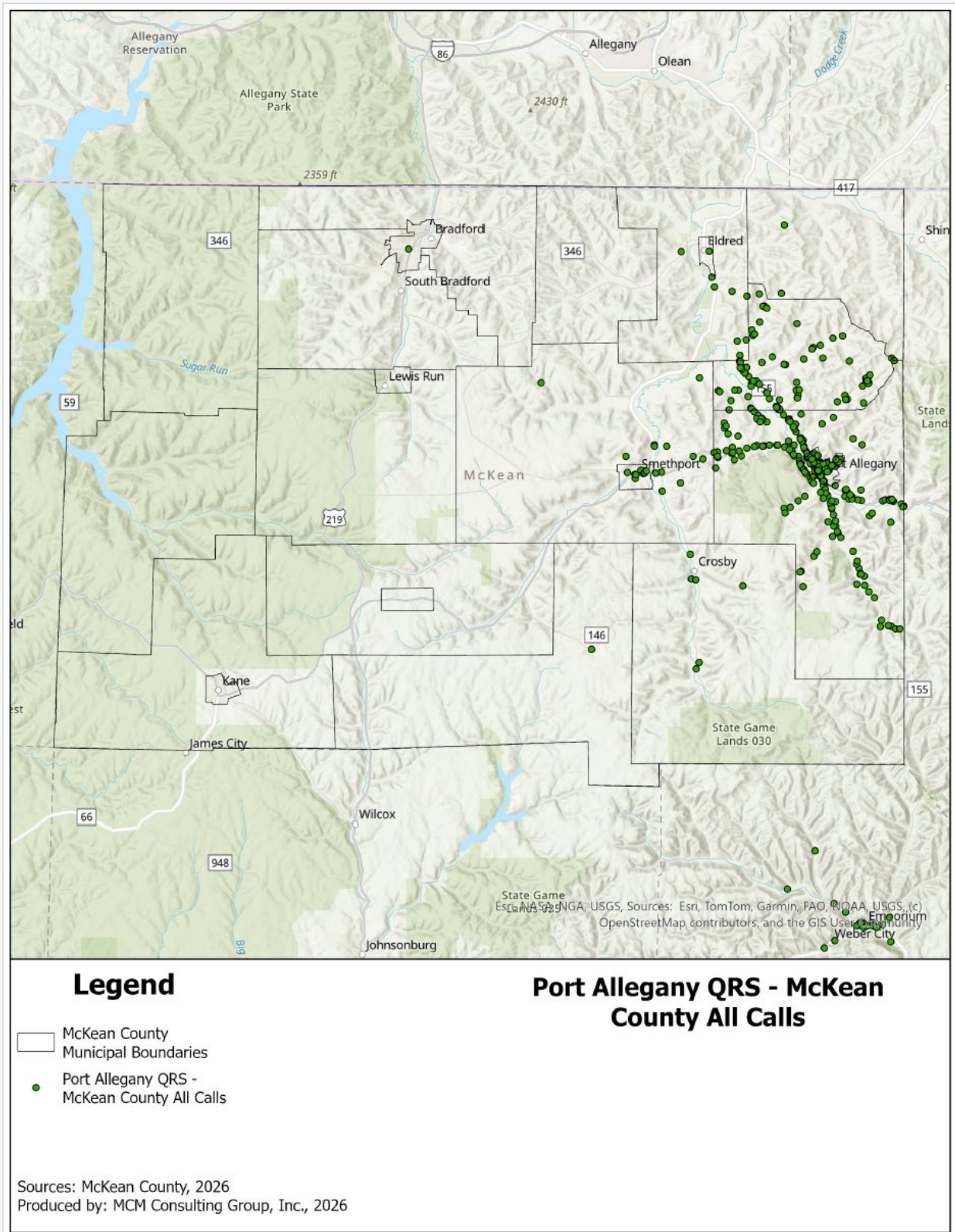


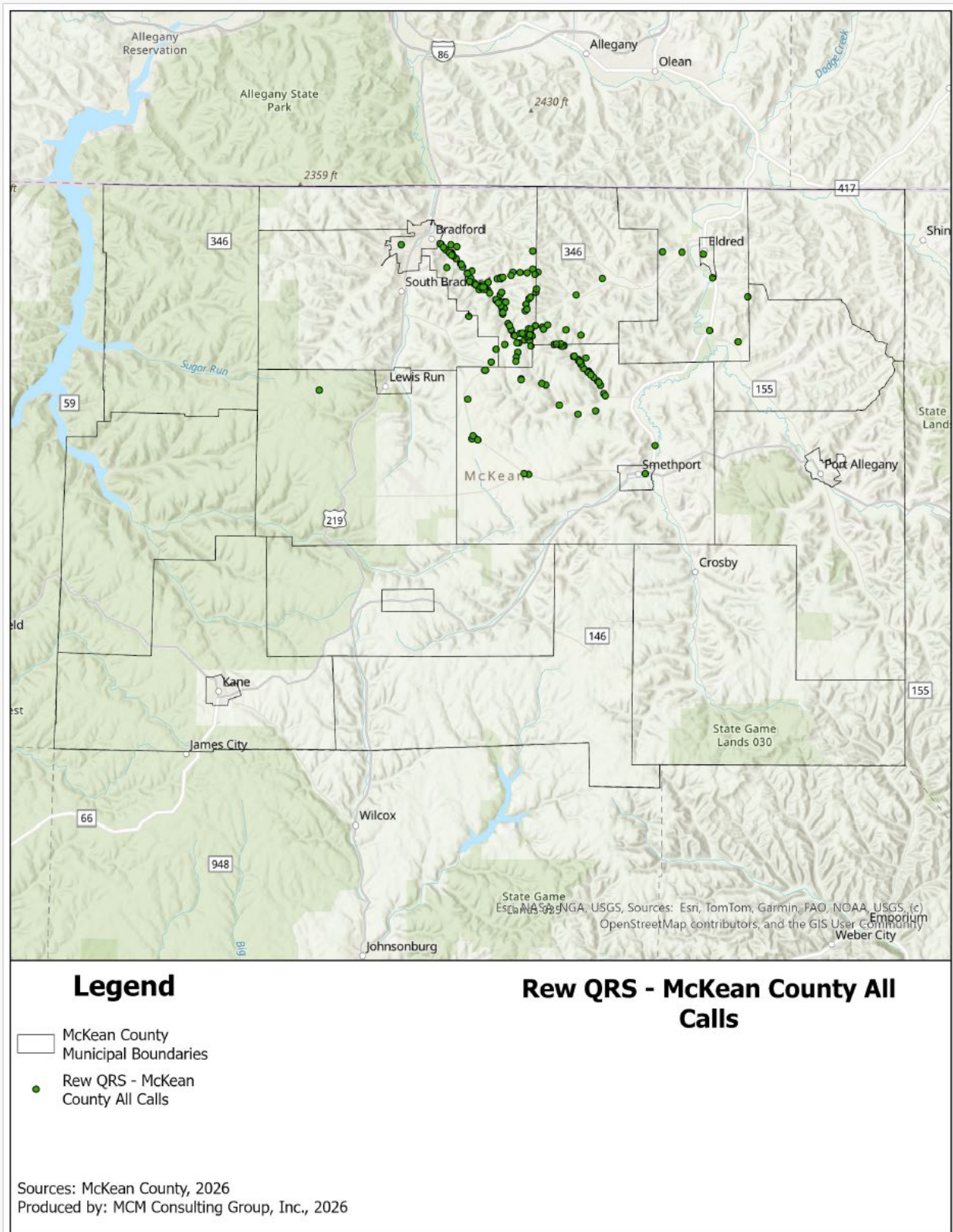














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Appendix E – Rural Ambulance Service Budget Model

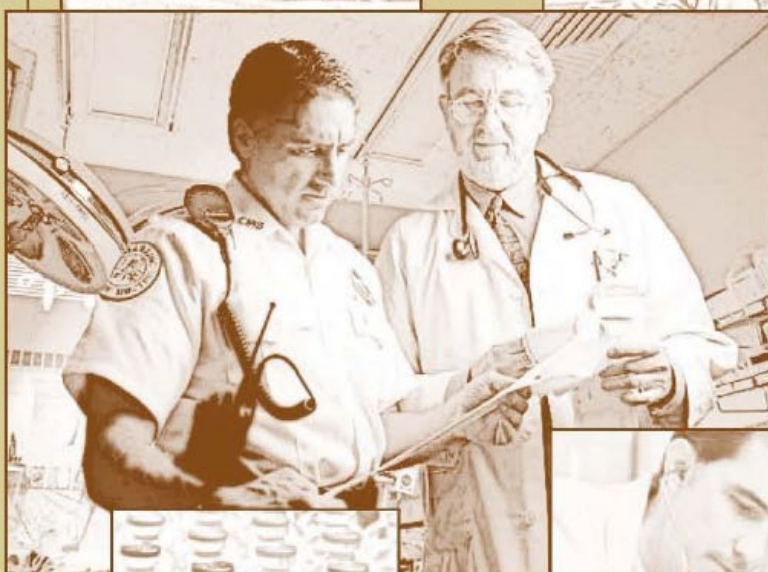


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RURAL AMBULANCE SERVICE BUDGET MODEL



U.S. Department of Health and Human Services
Health Resources and Services Administration (HRSA)
Office of Rural Health Policy (ORHP)

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration





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Rural Ambulance Service

Budget Model

U.S. Department of Health and Human Services

Health Resources and Services Administration

Office of Rural Health Policy



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Foreword

We are very pleased to offer you the **Rural Ambulance Service Budget Model**. This budgeting and financial management tool is an important part of the financial toolkit under development for rural ambulance services and rescue squads that do not have the resources to purchase such tools themselves. We recognize that rural ambulance services are an essential component of rural health care systems. Budgeting and financial management is but one of the many challenges facing rural Emergency Medical Services (EMS) agencies in the United States today. Rural EMS agencies also face such issues as recruitment and retention of qualified, trained human resources; increasing education and training requirements; increasing cost of equipment and increasing funding challenges, to name a few.

With capital and operating costs increasing and reimbursement decreasing, management of limited financial resources is becoming a more important component of rural ambulance service management and governance.

Marcia K. Brand, Ph.D.
Associate Administrator for Rural Health,
HRSA

The **Rural Ambulance Service Budget Model** provides a management tool that enables a service to enter known financial information into a simple, yet elegant preprogrammed spreadsheet. Once information is entered into the model, a budget is automatically calculated that can be exported into off the shelf accounting software and monthly budget versus actual results can be used to better manage limited funds and plan for improved financial management of the service.

This publication was developed by the Federal Office of Rural Health Policy, Health Resources and Services Administration in cooperation with the Rural Emergency Medical Services and Trauma Technical Assistance Center. It is hoped that this **Rural Ambulance Service Budget Model** will serve as a valuable tool for rural ambulance services and provide for better informed fiscal management in the challenging realm of out of hospital health care.

Please see the special note on the following page concerning the ongoing availability of this document.

Nels D. Sanddal, Director
Rural Emergency Medical Services and
Trauma Technical Assistance Center



A special note to the reader:

In FY 2000, Congress funded the Trauma and EMS Program within the Department of Health and Human Services, Health Resources and Services Administration (HRSA) to foster the development of appropriate, modern systems of such care. Ten percent of the funding provided for that program was earmarked for “rural” trauma and EMS and was administered by HRSA’s Office of Rural Health Policy (ORHP). In FY 03, ORHP established the Rural Emergency Medical Services and Trauma Technical Assistance Center (REMSTTAC). This product represents one of the deliverables identified in the REMSTTAC contract. Congress zeroed out the HRSA Trauma and EMS Program in FY 05 and ORHP, therefore, lost the resources necessary to continue REMSTTAC. However, as part of ORHP’s ongoing commitment to rural EMS, this and other products will continue to be available from two sources. These include the Critical Illness & Trauma Foundation (www.citmt.org) [not a government Web site], the parent organization of the previously funded REMSTTAC, and the Rural Assistance Center (www.RAConline.org) [not a government Web site]



OVERVIEW

In the early stages of the development of the Rural EMS and Trauma Technical Assistance Center (REMSTTAC) a diverse group of stakeholders were brought together to provide input and direction regarding how the TA center might best meet the needs of its constituency groups. These three groups are broadly defined as:

- Federal Agencies and national EMS, trauma, and rural health organizations with interest in or responsibility for rural EMS and trauma and their intersection with rural health.
- State EMS lead agencies, State Offices of Rural Health, and similar State level organizations that relate to rural EMS, trauma, and overall rural health.
- Local and regional EMS and trauma providers, including rural ambulance services, hospitals, rural health clinics, and other agencies and organizations involved in regional and local health planning and provision.

In developing and prioritizing the REMSTTAC scope of work, the stakeholder group recommended the development of a financial tool kit that would provide specific financial and budgeting tools to rural EMS agencies and organizations that may be managed by volunteer EMS providers or others with limited experience or training in the financial and budgeting aspects of public, private or not-for-profit organizations. As cited in the Rural and Frontier EMS Agenda for the Future (2005), many rural and frontier EMS services “have no expertise or infrastructure for collecting fees or maintaining the business functions.” The need for this toolkit has been further validated through a series of “town hall” meetings conducted in the intermountain west and New England States with representation from local EMS leadership.

In response to this direction, a task group was organized within REMSTTAC to develop tools for this financial tool kit. The task group, coordinated by a REMSTTAC staff person, includes a business/financial consultant and representatives of: the National Association of State EMS Officials, the Rural Health Resource Center and the National Association of Emergency Medical Technicians (EMTs). In addition to the considerable knowledge and expertise of these task group members, tasks and priorities are reviewed by the entire stakeholder group. Their input and direction guides the work of the task group. The task group and stakeholders identified the following priorities for toolkit development:

- A financial Chart of Accounts that identifies common elements of assets, liabilities, revenues, and expenses applicable to a rural EMS agency or organization
- A budget tool that assists rural EMS agencies and organizations in developing and tracking operating budgets and establishing fee schedules
- Instructions for using a budgeting tool and interface with common “off the shelf” accounting software that is readily available at low cost to rural EMS agencies or organizations.



The **Sample Chart of Accounts** represents the first drawer in the Financial Toolkit. It provides a bookkeeping and accounting framework for rural EMS services and is consistent with generally accepted accounting principles. It is organized as follows:

- **Assets** – These accounts represent both cash and non-cash assets and include bank accounts, accounts receivable, fixed assets such as property, plant and equipment with allowances for applicable depreciation of such assets.
- **Liabilities and Equity** – These accounts represent accounts payable, loans and lines of credit as well as earnings and owners' equity or fund balances, depending on the type and structure of the organization.
- **Revenue** – These are income accounts such as revenues from patient billing, other revenue, subsidies, etc. and are applicable to either cash basis or accrual basis accounting rules.
- **Expense** – These accounts represent the costs of doing business, such as payroll, fringe benefits, costs of occupancy, repairs, maintenance, and similar expense items.

Some EMS services may not need all the items shown in the sample Chart of Accounts. Others may find the need to add accounts. Either way, the sample provides a model with the most commonly used accounts in the accounting structure of a rural EMS organization.

<i>Sample Chart of Accounts</i>			
Assets		Liabilities/Equities	
1000	Cash	4001	Patient Revenue - Medicare
1200	Accounts Receivable	4002	Patient Revenue - Medicaid
1300	Prepays	4003	Patient Revenue - Other
1400	Inventory		
1500	Investments	4100	Grant / Subsidies Revenue
1600	Property, Plant and Equipment	4200	Investment Income
1700	Other Assets	4300	Other Income
2000	Accounts Payable	5000	Contractual Adjustments - Medicare
2100	Short Term Debt	5001	Contractual Adjustments - Medicaid
2200	Accrued Salaries	5002	Contractual Adjustments - Other
2300	Other Accrued Liabilities		
2400	Long-term debt		
3000	Net assets/Equity - Unrestricted		
3100	Net assets/Equity - Restricted		



Expenses			
6101	Salaries-Patient Care	6342	Legal Fees
6102	Benefits-Patient Care	6343	Collection Agency Fees
6103	Medical Supplies - Patient Care	6344	Software Maintenance Contracts
6104	Gases (oxygen) - Patient Care	6345	Consulting Fees
6105	Drugs - Patient Care	6346	Service Contracts
6106	Laundry & Linen - Patient Care	6347	Management Contract
6107	Equipment Depreciation - Patient care	6348	Claim Processing Contract
6108	Equipment Repair - Patient Care	6350	Dues & Memberships
6109	Minor Equipment - Patient Care	6351	Licenses
6110	Training - Patient Care	6352	Donations
6111	Books & Periodicals - Patient Care	6353	Food
6112	Travel & Entertainment - Patient Care	6360	Printing & Publication
6201	Dispatch Salaries	6400	Interest Expense
6202	Dispatch Benefits		
6203	Dispatch Supplies	6503	Facilities Supplies & Services
6207	Dispatch Equipment Depreciation	6507	Building Depreciation
6209	Dispatch Minor Equipment	6508	Building Maintenance
6213	Telephone	6570	Building Rent
6214	Radio Maintenance	6571	Property Taxes
6215	Radio Antenna	6572	Utilities
6216	Cell Phones	6573	Housekeeping
6217	Pagers	6574	Laundry - Non Patient Care
		6575	Uniforms
6301	Administration Salaries	6576	Property Insurance
6302	Administration Benefits		
6303	Office Supplies	6680	Vehicle Registration
6307	Office Equipment Depreciation	6681	Vehicle Gas & Oil
6308	Office Repair & Maintenance	6682	Vehicle Repairs
6309	Office Minor Equipment	6683	Vehicle Depreciation
6311	Books & Periodicals	6684	Vehicle Leases
6312	Travel & Entertainment	6685	Auto Insurance
6313	Administration Telephone	6400	Interest Expense
6320	Worker's Comp		
6321	Unemployment Tax	6503	Facilities Supplies & Services
6322	FICA Tax	6507	Building Depreciation
6323	General Liability Insurance	6508	Building Maintenance
6324	Professional Liability Insurance	6570	Building Rent
6325	Umbrella Coverage	6571	Property Taxes
6326	Health Insurance	6572	Utilities
6327	Pension Plan		
6340	Physician Fees		
6341	Accounting Fees		



The **Rural Ambulance Service Budget Model (RASBM)** fills a very large drawer in the REMSTTAC Financial Toolkit. The Budget Model is a customized Microsoft Excel® spreadsheet. Part of the Microsoft Office® software family, Excel® is commonly available to most computer users and is often bundled on computers marketed in the U.S. Where Excel® is not already installed on a personal computer, the software can be purchased inexpensively from most office supply stores or on-line software vendors. If you have other spreadsheet software REMSTTAC will assist you in the conversion or importation of this template.

This tool was developed to assist rural ambulance services in establishing an annual budget. It also helps calculate the value of services donated to the ambulance service by another entity and the value of donated services provided by the ambulance staff to the community.

Why should you prepare and use a budget? A budget is a record and forecast of all cash sources and cash expenditures. Maintaining a budget allows you to estimate future needs and profits and to plan for managing any discrepancies. At minimum, your budget should track the expenses of running your service compared to the money generated. A detailed budget will allow you to do much more than simply track revenue and expenses; it will provide the framework for quantifying the overall value of your ambulance service. This becomes especially important when seeking community support, reporting to oversight boards or committees, and in applying for grants or loans. The Rural Ambulance Service Budget Model provides step-by-step instructions for organizing important data regarding your service.

By simply opening this Excel® file the user can input known or easily obtainable information into the spreadsheet. The following tutorial provides a detailed, easy to follow procedure for obtaining and entering necessary data into the budget model. When the worksheet variables are filled, the model automatically calculates and displays information that provides the user with an operating budget and information for establishing a fee schedule (for those ambulance services that charge for their services). The Budget Model file consists of a series of spreadsheet "tabs", all of which are interrelated for calculation purposes. The "tabs" are labeled as follows:

- Introduction
- Demographics
- Vehicles
- Building
- Other Capital
- Staffing
- Training
- Other Expenses
- Budget
- Rate Study



The first step in using this REMSTTAC Budget Model is to copy the .xls file from the enclosed CD ROM onto your computer hard drive. This file should reside in the directory on your hard drive where other Excel® spreadsheet files are maintained. **Do not attempt to fill in your service information on the file on the CD ROM.**

DISCLAIMER:

The rural EMS industry is widely diverse and this budget model will not be appropriate for, nor was it intended to serve, all ambulance services. Ambulance services are encouraged to engage the services of a professional accountant as necessary.

Future Efforts:

The REMSTTAC Budget Model and its associated Chart of Accounts are the first of several drawers in the Financial Toolkit to be developed. Additional tools under consideration are:

- Cash flow management tools
- Accounts receivable management tools
- Billing and third party payer tools
- Others as identified by the Financial Toolkit task group and the REMSTTAC stakeholder group

We welcome your feedback on the REMSTTAC Budget Model and associated Tutorial.

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Rural Ambulance Service Budget Model

INTRODUCTION

Congratulations! You've taken an important first step in deciding to use the budget model tool provided by the Department of Health and Human Services, Health Resources and Service Administration's Office of Rural Health Policy (ORHP). This product was developed by the Rural Emergency Medical Services & Trauma Technical Assistance Center (REMSTTAC) under a previous contract with ORHP.

This tool was developed to assist rural ambulance services in establishing an annual budget. It also provides some utility in demonstrating the value to a community for services donated to the ambulance service by another entity (such as dispatch functions provided free by the sheriff), and the value of donated services provided by the ambulance staff to the community (such as the value of volunteer labor contributions). The tool is one of a series of "EMS Management Tools" being produced.

The model will also give you the ability to upload our national standard EMS Chart of Accounts and the budget you develop directly into the Intuit's QuickBooks® program. QuickBooks® is a proprietary accounting program that can help you manage your finances, print reports, provide payroll functions, and more. We chose QuickBooks® to provide an interface because Intuit supports it fully on-line and provides comprehensive help and training.

Limitations:

The rural EMS industry is widely diverse and this budget model will not be appropriate for, nor was it intended to serve, all ambulance services. Ambulance services are encouraged to engage the services of a professional accountant as necessary.

Notes about the Model:

This model consists of a series of visible and hidden rows and columns. It is designed to be completed sequentially; however it is possible to start one section, skip part, and then return. **Green areas** of the worksheet are always fine to fill in. **Yellow areas** provide caution or an either/or Statement. Filling in **red sections**, or any section on the budget page will override formulas. Do so with caution and monitor the effect on the rest of the model. These areas should be changed only by those with strong expertise in spreadsheet design and use.

Let's Get Started:

First, print the document included in this package called "Budget Model Worksheet.doc". Keep it handy: we'll be filling it in as you move along in this tutorial. Next, open the budget model by double clicking on the "Budget Model.xls" file. The first page you see is the Demographics page.



SPREADSHEETS

	A	B	C	D	E
1	Rural EMS & Trauma Technical Assistance Center				
2	Ambulance Service Budget Model				
3	Demographics				
4	Ambulance Service Name: Test Ambulance Service				
5	Administrator/Chief Name:				
6	Address Line 1:				
7	Address Line 2:				
8	City, State, Zip Code:				
9	County:				
10	Telephone Number:				
11	Fax Number:				
12	Emergency Ambulance Runs Last Year				
13	Non-Emergency Ambulance Runs Last Year				
14	Loaded Miles Driven Last Year				
15	I am preparing a budget for the year:				
16	2006				
17	The name entered here will appear on all subsequent worksheets				
18	QuickBooks				
19	Demographics				
20	Vehicles				
21	Building				
22	Other Capital				
23	Staffing				
24	Training				
25	Other				
26	Other				
27	Other				
28	Other				
29	Other				
30	Other				
31	Other				

If you are familiar with spreadsheets, skip to the next page. If you're not, here's a little primer.

Spreadsheets are organized into columns and rows. Columns are identified by letters (A to Z and then AA to ZZ, and so on). Look at the words "Test Ambulance Service" above, (they are at the top of the yellow area). The area those words appear in is called a cell. The reference for that cell is B6. That is because those words appear going across the top in column B and going down to row six. The cell reference for the words "I am preparing a budget for the year:" is A19. The words in cell C7 are "on all subsequent worksheets".

Now look at the bottom of the graphic. Under the number for row 31 you see a group of four arrows pointing left or right and then seven words: *QuickBooks*, *Demographics*, *Vehicles*, *Building*, *Other Capital*, *Staffing* and *Training*. (Your spreadsheet program may display some, all, or all of these plus others.) These are tabs. We're working on the *Demographics* tab right now. To switch to the *Vehicles* tab, click on the word *Vehicles* and that tab will be displayed.

If you need more assistance in learning about spreadsheets, please refer to the Help



function on your spreadsheet program.

Demographics:

What this tab does: The transport and miles information you enter on this page will become important as you get to the final steps of the model. You will use them to help determine what you will need to set your rates at in order to cover your costs.

	A	B	C	D	E
1	Rural EMS & Trauma Technical Assistance Center				
2	Ambulance Service Budget Model				
3					
4	Demographics				
5					
6	Ambulance Service Name:	Test Ambulance Service	The name entered here will appear		
7	Administrator/Chief Name:		on all subsequent worksheets		
8	Address Line 1:				
9	Address Line 2:				
10	City, State, Zip Code:				
11	County:				
12	Telephone Number:				
13	Fax Number:				
14					
15	Emergency Ambulance Runs Last Year				
16	Non-Emergency Ambulance Runs Last Year				
17	Loaded Miles Driven Last Year				
18					
19	I am preparing a budget for the year:	2006			
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					

Navigation: Demographics / Vehicles / Building / Other Capital / Staffing / Training / Other

On this tab you will enter the name and other information about your ambulance service. In cell B15, enter the number of emergency ambulance runs your service performed last year that resulted in a bill being sent. Do not include responses that did not result in a bill. In cell B16, follow the same procedure to record the number of non-emergencies. In cell B17, enter the total number of miles billed. Try to be accurate with these numbers, they are important later.

STOP – IT IS TIME TO SAVE YOUR WORK.

This is the first save of your work. To save your file to your hard drive, click on File and then Save-As. Choose a location on your computer to save your work. Rename the file if you would like. We'll have you save your data frequently as you work through this tutorial, always to the same place. Also, if you take a break, when you come back to continue working, be sure to open the saved spreadsheet from your hard drive, not the template version you opened to begin this tutorial.

Now it's time to move to the *Vehicles* tab.



Vehicles:

What this tab does: The information you enter on this page feeds necessary information to your final budget. For vehicles you lease, it will transfer the lease costs into your budget. For vehicles you purchase, it will set up depreciation. Depreciation is an important part of your final budget. By depreciating over time, you will be saving money in the bank to replace your vehicles when their useful life is exhausted. Since the cost of vehicles will increase over time, depreciation alone will not produce enough cash to meet the increased price when replacement is necessary. You will need to supplement depreciation with either cash reserves, or funds produced another way.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Rural EMS & Trauma Technical Assistance Center													
2	Ambulance Service Budget Model													
3														
4	Test Ambulance Service													
5														
6	Feel free to over-write the ambulance or vehicle with your unit numbers. Information entered on this sheet will transfer													
7	to the other sheets.													
8														
9	Do you replace ambulances based on their age or mileage?										If you make lease payments, do not			
10	If by age, how many years?										fill in the cost or mileage information.			
11	If by mileage, what number of miles?													
12														
13														
14														
15														
16														
17														
18														
19														
20														
21														
22														
23														
24														
25														
26														
27	Do you replace non-ambulance vehicles (if any) based on their age or mileage?										If you make lease payments, do not			
28	If by age, how many years?										fill in the cost or mileage information.			
29	If by mileage, what number of miles?													
30														
31														
32														
33														
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35														
36														
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38														
39														
40														
41														
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99														
100														

Let's make this friendly for you first. Click on cell A16 and replace the words "Ambulance #1" with terminology that is familiar to you. Call it Unit 101, Squad 54, or whatever label will help you recognize this as your primary ambulance. If you have more than one ambulance, replace the text in A17 through A25 similarly.

If you are LEASING any of these ambulances, enter the monthly lease amount in the yellow area on the same row as that vehicle. For leased vehicles, you will not complete columns C to G.



For all vehicles - LEASED AND OWNED - fill in columns K (Vehicle License), L (Vehicle Registration) and M (Insurance). In column K, fill in the amount paid in vehicle licensing fees from your State EMS agency, if any, for all vehicles. The amount should be an annual amount, so if the State charges you once every two years, divide the total by two and enter that amount. Column L is for vehicle registration and license plates from your State vehicle licensing bureau, if any, for all vehicles. Enter an annual amount. Column M is for one year of vehicle insurance. Fill in the annual amount for each of the ambulances.

If you LEASE your vehicles follow the same process as above for any non-ambulances you might have, using rows 32-36. Then, you're done with this tab, unless you also own some of your vehicles.

We'll use columns C to G for vehicles you OWN (or are making loan payments). If you normally replace your vehicles based on a specific number of years, enter the number of years in cell G10. If you normally replace vehicles when their mileage hits a specific level, enter the target number of miles in G11. Do NOT put values in both cells, but also make sure you fill in one of them. If you don't follow either of these replacement milestones, pick one and estimate a number for it.

For each owned ambulance enter the following information: Cell C16 (through C25) – the year the ambulance was acquired. Cell D16 (through D25) – the cost of the vehicle the year it was purchased. Cell E16 (through E25) – the cost of any capital equipment you purchased with the ambulance.

Many ambulance services will purchase new stretchers, mobile radios, defibrillators and other capital equipment each time they purchase an ambulance. If you follow this process, enter the total value of capital items that are purchased with the vehicle. Capital is commonly defined as those items that cost more than \$500 and have a useful life exceeding one year. It is important to keep track of what equipment is represented in this figure. It will roll into the total vehicle depreciation calculation; therefore, it should not be listed again later with other capital equipment.

Cells F16 and G16 (through F25 and G25) – if you entered a number of years in cell G10, you do not need to fill in these numbers; your depreciation will be calculated based on the number of years the vehicle is in service. If you entered a number of miles in G11, then you need to complete F16 and G16. In F16, enter the odometer reading of your vehicle at the beginning of the previous 12 month period and the odometer reading at the end of the 12 month period. Since you replace your vehicles based on miles driven, depreciation will be calculated based on the total number of miles driven last year.

Complete the same information on rows 32-36 for all non-ambulances you own or lease.

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Now it's time to move to the *Building* tab.



Building:

What this tab does: The *Buildings* tab will record rent and mortgage information. It sets up depreciation for buildings owned by the ambulance service. In addition, it estimates the value of space donated for your use. Pay attention to donated space for two reasons: first, it will help you understand the value of the donation, and secondly, you can publicly report the value of the donation.

	A	B	C	D	E	F	H	I
1	Rural EMS & Trauma Technical Assistance Center							
2	Ambulance Service Budget Model							
3								
4	Test Ambulance Service							
5								
6								
7	Donated Space	Square Feet	Value per Square Foot					
8								
9	Garage Space		\$ 10.00	For donated space just fill in the number of square feet. Example: 1 ambulance bay at 12 feet by 12 feet is 144 square feet (12x12=144)				
10	Office Space		\$ 15.00					
11	Meeting Rooms		\$ 15.00					
12	Other Space		\$ 12.00					
13		Monthly Lease Payment						
14	Leased Space							
15								
16	Building #1	Feel free to change the building name to something that makes sense to you. All future spreadsheets will display what you enter here.						
17	Building #2							
18	Building #3							
19	Building #4							
20								
21								
22								
23	Owned Buildings	Original Cost	Term in Years	Interest Rate	Annual Payments	Override the annual payments if you know the amount but not the cost, term or interest rate		
24								
25	Building #1		30		\$0.00			
26	Building #2		30		\$0.00			
27	Building #3		30		\$0.00	Feel free to change the building name to something that makes sense to you. All future spreadsheets will display what you enter here.		
28	Building #4		30		\$0.00			
29								
30								
31								

Rows 7-12 are for donated space. For each category of space, enter the number of square feet in column B. Column C has some default square footage price estimates. If you know a specific value for your area, you can override these numbers with actual values.

Rows 14-20 are for lease payments made for space you occupy but don't own. Enter your monthly lease payment for each building.

Rows 23-28 are for buildings you own. If you know the original cost, interest rate and mortgage term, enter those values and the annual payment amount will be automatically calculated. As an alternative, if you know the annual mortgage cost, you can just type it into the red area. NOTE: for owned buildings, enter ANNUAL information and for leased buildings, enter MONTHLY lease payments.

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Now it's time to move to the *Other Capital* tab.



Other Capital:

What this tab does: The *Other Capital* tab collects information to set up depreciation for capital items that are not included on the *Vehicles* tab. Capital items are those that cost over \$500 and have a useful life that exceeds one year.

	A	B	C	D	E	F	G	H	I
1	Rural EMS & Trauma Technical Assistance Center								
2	Ambulance Service Budget Model								
3									
4	Test Ambulance Service								
5									
6				Purchase	Years				
7	Communications		Cost	Useful Life	Depreciation				
8	Base Stations			10	\$0				
9	Repeaters, Towers			10	\$0				Feel free to change the names of equipment and the useful life listed in the first column anywhere on this page.
10	Vehicle Radios			10	\$0				
11	Pagers, Radios, Phones			5	\$0				
12	Other			5	\$0				If you know actual depreciation you may change the red areas.
13									
14	Patient Care Equipment								
15	Stretchers			5	\$0				
16	Defibrillators			10	\$0				
17	Other			5	\$0				
18									
19	Mechanic Tools, Equipment								
20	Mechanic			20	\$0				
21									
22	Office Equipment								
23	Furniture			5	\$0				
24	Computers			5	\$0				
25	Other			5	\$0				
26									
27									
28									
29									
30									
31									

The *Other Capital* tab has 4 categories common capital equipment: communications, patient care, mechanic and office equipment. If you have equipment that doesn't fit into one of these categories, you'll have to make it fit somewhere. Use one of the "other" categories on rows 12, 17 or 25. Type over the word "other" to remember what equipment you placed there.

In each category, enter the purchase cost of the item(s) purchased. Feel free to change the number of years in the "Years Useful Life" columns. If you included your stretcher(s) or defibrillator(s) as equipment on the vehicle tab, do not enter them here.

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Now it's time to move to the *Staffing* tab.



Staffing:

What this tab does: The *Staffing* tab collects information about how you staff your ambulance service and will estimate your salary costs for next year.

	A	B	C	D	E	F	G	H	I	J	K	L
1	Rural EMS & Trauma Technical Assistance Center											
2	Ambulance Service Budget Model											
3												
4	Test Ambulance Service											
5												
6			Hours Per		OR							
7	Administration		Week	Rate/Hr	Annual							
8	Administrative Position #1				\$ -	Either specify hours per week and a rate						
9	Administrative Position #2				\$ -	OR enter an annual amount.						
10	Administrative Position #3				\$ -							
11	Administrative Position #4				\$ -							
12	Administrative Position #5				\$ -							
13												
14			# of Crew	Hours per	Hourly	Pay Per	# of	OR				
15	Ambulance Staff		Members	day	Rate	Transport	Transports	Annual				
16	Ambulance #1							Cost				
17	Ambulance #2							\$ -	Either use the green sections			
18	Ambulance #3							\$ -	OR enter an annual amount.			
19	Ambulance #4							\$ -				
20	Ambulance #5							\$ -				
21	Ambulance #6							\$ -				
22	Ambulance #7							\$ -				
23	Ambulance #8							\$ -				
24	Ambulance #9							\$ -				
25	Ambulance #10							\$ -				
26												
27												
28			# of Crew	Hours per	Hourly			Annual				
29	Communications		Members	day	Rate			Cost				
30	Administrative							\$ -	Either use the yellow sections			
31	Dispatcher							\$ -	OR enter an annual amount.			
32												
33	Rural EMS & Trauma Technical Assistance Center											

Let's make this friendly for you. If you have administrative staff, type over the label Administrative Position #1 in cell A8 with either the name or job classification for the person filling the role. If you have more than one administrative position (billing, secretary, etc.) do the same on A9 to A12.

For administration, you will either enter the hours worked per week in column C and the rate per hour in column D, or you can type in an annual amount in column E.

Whether you staff full-time, volunteer or some combination of each, the ambulance staff section should work for you. This section is organized around your ambulance vehicles. If you have full-time staff or pay an on-call stipend to volunteers, you'll use columns E and F. If you pay your staff a per-run stipend, you'll use columns G and H. If you already know your annual salary costs, you can simply enter those in column J.

Example: ABC ambulance service staffs one ambulance 24 hours a day with two full-time staff. They have a second ambulance which uses on-call staff that are each paid \$2 per hour while on call, and \$20 per run. On their 500 billable runs, the full-time staffed ambulance completes 450 and volunteers complete the other 50.



In cell D16 enter “2” to represent the two full time staff. In cell D17 enter “2” to represent the volunteers on call. In E16 and E17 enter 24, to represent around the clock staffing.

In cell F16 you will enter the average pay rate of the full-time staff. If your staff are paid different hourly rates depending on their longevity with the service, simply add up all of their pay rates and divide by the number of employees and this will give you the average hourly rate. The typical ambulance service will pay some overtime during the course of the year. Estimate the number of overtime hours and fill in the blocks below. Use that result as the Hourly Rate for cell F16.

	<i>Calculation</i>	<i>Result</i>
Number of hours per year	24 hours times 365 days	8,760
Average hourly pay rate	XXXXXXXXXXXX	
Estimated annual number of hours of overtime pay	XXXXXXXXXXXX	
Average hourly pay rate at time and one-half	Average hourly pay rate times 1.5	
Annual Regular Pay	Number of hours per year (8,760) times average hourly pay rate	
Annual Overtime Pay	Number of overtime hours per year times average hourly pay rate at time and one-half	
Total Pay	Annual Regular Pay Plus Annual Overtime Pay	
Average hourly pay including overtime factor	Total Pay divided by number of hours per year (8,760)	

In cell D16 enter “2” for the volunteers that are on call. In cell E16 enter 24. In cell F16 enter “2” for the \$2 per hour call time. In cell G16 enter 20 for the per-run stipend and in cell H16 enter 50 – the number of transports completed by the volunteers.

Use a similar process to enter the information for communications and mechanic staff (if any).

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Now it’s time to move to the *Training* tab.



Training:

What this tab does: The *Training* tab collects information about your ongoing education costs.

	A	B	C	D	E	F	G	H	I	J
1	Rural EMS & Trauma Technical Assistance Center									
2	Ambulance Service Budget Model									
3										
4	Test Ambulance Service									
5										
6										
7										
8					State/Natl	Continuing				
9					Certification/	Ed/Refresher		Other		
10	Administration				License Fee	Cost	Conference	Training	Total	
11	Administrative Position #1									\$ -
12	Administrative Position #2									\$ -
13	Administrative Position #3									\$ -
14	Administrative Position #4									\$ -
15	Administrative Position #5									\$ -
17	Ambulance Staff		Number							
18	First Responders/Drivers									\$ -
19	EMTs									\$ -
20	Paramedics									\$ -
21	Nurses									\$ -
22	Other									\$ -
24	Communications		Number							
25	Administrative									\$ -
26	Dispatcher									\$ -
28	Mechanics		Number							
29	Administrative									\$ -
30	Mechanics									\$ -
32								Total		\$ -
33										
34										
35										

The amounts entered into this tab should be ANNUAL amounts per person. Many States require certification/licensure renewal every two or three years. If your service pays these fees or reimburses staff for them, divide the fee paid by the number of years the certificate/licensure is valid. See an example on the Budget Model Worksheet for how to calculate this result. The example is based on a State certification/licensure fee of \$40 for four years and a National Registry fee of \$25 for two years.

Use a similar process to calculate the annual cost of refresher courses if your service pays for them. If your service pays for conference attendance, include the average cost of conference registration plus travel expenses in column G.

If there is other training that you pay for (for example ACLS or PALS courses), report an average ANNUAL amount that includes reimbursed travel costs. For example, let's say you pay a registration fee of \$150 and reimburse on average \$50 in travel related costs for ACLS. Since the refresher course is every two years, the cost per two year cycle per person is \$200. However, you should report the ANNUAL cost per person (\$100).

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Now it's time to move to the *Other Expenses* tab.



Other Expenses:

What this tab does: This tab collects information about expenses that have not been recorded elsewhere on any tabs.

	A	B	C	D	E
1	Rural EMS & Trauma Technical Assistance Center				
2	Ambulance Service Budget Model				
3					
4	Test Ambulance Service				
5					
6	Patient Care				
7	6103 Medical Supplies-Patient Care			Please do not change the account numbers or descriptions on this page. They are part of a national standardized EMS accounting system. Include the cost of uniforms, coats, etc., on this line.	
8	6104 Gases (oxygen)-Patient Care				
9	6105 Drugs-Patient Care				
10	6106 Laundry & Linen-Patient Care				
11	6108 Equipment Repair-Patient Care				
12	6109 Minor Equipment-Patient Care				
13	6111 Books & Periodicals-Patient Care				
14	6112 Travel & Entertainment-Patient Care			Enter items on this page that have not been covered earlier in the worksheet	
15	Dispatch				
16	6203 Dispatch Supplies				
17	6209 Dispatch Minor Equipment				
18	6213 Telephone				
19	6214 Radio Maintenance				
20	Administration				
21	6303 Office Supplies				
22	6308 Office Repair & Maintenance				
23	6309 Office Minor Equipment				
24	6311 Books & Periodicals				
25	6312 Travel & Entertainment				
26	6313 Administration Telephone				
27	6320 Worker's Comp				
28	6321 Unemployment Tax				Note: On the next sheet, benefits are automatically calculated as a percentage of payroll (30% unless you adjust it. If you wish to use actual numbers in these red cells, be sure to adjust the benefits accordingly on the next sheet.
29	6322 FICA Tax				
30	6323 General Liability Insurance				
31	6324 Professional Liability Insurance				
32	K / Vehicles / Building / Other Capital / Training / Other Expenses / Budget / Rat /				

This tab requires some detective work on your part. You will need to go through your records from last year to determine the total amounts paid for these various categories. The tab is organized into six different sections: patient care expenses, dispatch expenses, administrative expenses, interest expense, building expenses, and vehicle expenses.

DO NOT CHANGE THE ACCOUNT NUMBERS OR DESCRIPTIONS ON THIS TAB. They are part of a national standard EMS Chart of Accounts. If you don't see a category that matches the way you have previously recorded your expenses, you'll need to find the best fit. If you use QuickBooks® or some other proprietary software, you can set-up sub-accounts to these categories later to match the way you keep track of expenses.

On the *Budget* tab that follows this one, some benefit costs will be automatically calculated for you, using an average benefit rate of 30 percent of salary. If you don't want to use this average rate and you know the actual costs of the red areas in column C, fill in the actual amount in the benefits cells under patient care, dispatch and administration in column C. Change the (0.3) in the formula to reflect your actual benefit percentage.

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Now it's time to move to the *Budget* tab.

Rural Ambulance Service Budget Model

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Budget:

What this tab does: This tab displays the calculations and amounts entered on all previous tabs. It also demonstrates the value of contributed items, either by other agencies to yours, or by your volunteer staff. It uses an inflation factor to increase your budget amounts from last year to the current year.

	A	B	C	D	E	F	G	H	I	J
1	Rural EMS & Trauma Technical Assistance Center									
2	Ambulance Service Budget Model									
3										
4	Test Ambulance Service									
5										
6										
7										
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About the patient care section: If you elected to fill in the red cells in the previous tab for benefits you should make the amount in cell C11 "0." Otherwise, benefits will be reported twice. If your total employee salaries do not equate to at least \$10 per hour for two people, cells F10 and F11 will report an amount that volunteers contribute. This number can be a powerful tool for you as you report the estimated dollar value you provided to the community through the volunteers' service. Feel free to change the Percent Inflation on any or all of the rows in column D to match your particular circumstances. Column G is calculated by taking the actual or estimated information in column C times the inflation factor in column E for that row.

About the dispatch section: Many ambulance services do not operate their own dispatch centers; the service is dispatched by the police or sheriff's departments. If you haven't reported an amount equivalent to \$15 per hour, 24 hours a day in dispatch salaries, this sheet will estimate the value that your dispatch center provides to you. If you elected to fill in the red cells in the previous tab for benefits you should make the amount in cell C24 "0."



About the administrative section: Many ambulance services have part-time managers. If you have not reported at least \$15 per hour for 40 hours per week in administrative payroll costs, this sheet will report the value of the contribution to the service by your management staff. If you elected to fill in the red cells in the previous tab for benefits you should make the amount in cell C36 zero.

	A	B	C	D	E	F	G
1		Rural Emergency Medical Services & Trauma Technical Assistance Center					
2		Ambulance Service Budget Model Tool					
3							
4		Ambulance Service Name					
5							
6					Contributed	Contributed	
7					By	By	
8			Last	Percent	Community 1	Staff 2	Budget
9			Year	Inflation			
34		Administration					
35		6301 Administration Salaries	\$ -	3.00%		\$ 31,200	\$ -
36		6302 Administration Benefits	\$ -	3.00%		\$ 9,360	\$ -
37		6303 Office Supplies	\$ -	3.00%			\$ -

About the building section: Cell E24 will report the annual value given to the ambulance service for donated space that was reported on the building tab.

	A	B	C	D	E	F	G	H
64		6353 Food	\$ -	3.00%			\$ -	
65		6360 Printing & Publication	\$ -	3.00%			\$ -	
66		6361 Advertising	\$ -	3.00%			\$ -	
67		6362 Employment Agencies	\$ -	3.00%			\$ -	
68		Interest Expense						
69		6400 Interest Expense	\$ -	3.00%			\$ -	
70		Building					\$ -	
71		6503 Facilities Supplies & Services	\$ -	3.00%			\$ -	
72		6507 Building Depreciation	\$ -	3.00%			\$ -	
73		6508 Building Maintenance	\$ -	3.00%			\$ -	
74		6570 Building Rent	\$ -	3.00%	\$ -		\$ -	
75		6571 Property Taxes	\$ -	3.00%			\$ -	
76		6572 Utilities	\$ -	3.00%			\$ -	
77		6573 Housekeeping	\$ -	3.00%			\$ -	
78		6574 Laundry-non patient care	\$ -	3.00%			\$ -	
79		6576 Property Insurance	\$ -	3.00%			\$ -	
80		Vehicles						
81		6680 Vehicle Registration	\$ -	3.00%			\$ -	
82		6681 Vehicle Gas & Oil	\$ -	3.00%			\$ -	
83		6682 Vehicle Repairs	\$ -	3.00%			\$ -	
84		6683 Vehicle Depreciation	\$ -	3.00%			\$ -	
85		6684 Vehicle Leases	\$ -	3.00%			\$ -	
86		6685 Auto Insurance	\$ -	3.00%			\$ -	
87			\$ -		\$ 170,820	\$ 40,560	\$ -	
88								
89		Note 1: If there aren't costs included on the staffing sheet to pay one dispatcher at least minimum wage 24 hours a day, the cost of one dispatcher at an average \$15, less any amount indicated paid for dispatching fees is included in this column. Donated space is also reflected here as calculated on the Building sheet.						
90								
91								
92		Note 2: If there isn't enough costs per staffed ambulance to pay two people 24x7 at least minimum wage, then the donated services indicated here are calculated at \$10 per hour for each of 2 people 24x7 for each scheduled ambulance, less any amounts paid in salary costs on the staffing sheet. A similar method is used to determine at least one manager works full-time at \$15 per hour.						
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Rate Study:

What this tab does: This tab allows you to see the effect of varying base and mileage changes, based on the percentage of collections of your service.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Rural EMS & Trauma Technical Assistance Center														
2	Ambulance Service Budget Model														
3															
4	Test Ambulance Service														
5															
6	You entered the # of emergency and non-emergency trips and # of loaded miles (the red cells) on the demographics page.														
7	If you wish to see the affect of changes to these values, please change them on the demographics														
8															
9	EMERGENCIES														
10	Charge if you change the number in yellow, the other columns will automatically increase by 50 dollars.														
11	Emergency Calls	\$ 250	\$ 300	\$ 350	\$ 400	\$ 450	\$ 500	\$ 550	\$ 600	\$ 650	\$ 700	\$ 750			
12	Collections at 100%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
13	Collections at 90%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
14	Collections at 80%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
15	Collections at 70%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
16	Collections at 60%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
17	Collections at 50%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
18	Collections at 40%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
19	NON-EMERGENCIES														
20	Charge if you change the number in yellow, the other columns will automatically increase by 50 dollars.														
21	Non-emergency Calls	\$ 250	\$ 300	\$ 350	\$ 400	\$ 450	\$ 500	\$ 550	\$ 600	\$ 650	\$ 700	\$ 750			
22	Collections at 100%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
23	Collections at 90%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
24	Collections at 80%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
25	Collections at 70%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
26	Collections at 60%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
27	Collections at 50%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
28	Collections at 40%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
29	Mileage														
30	Charge if you change the number in yellow, the other columns will automatically increase by 50 cents.														
31	Loaded Miles	\$ 5.50	\$ 6.00	\$ 6.50	\$ 7.00	\$ 7.50	\$ 8.00	\$ 8.50	\$ 9.00	\$ 9.50	\$ 10.00	\$ 10.50			
32	Collections at 100%	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
33	Other Capital / Staffing / Training / Other Expenses / Budget / Rate Study /														

This tab is a tool for you to estimate what your charges will need to be in order to recoup your cost of providing service. The number of emergency calls, non-emergency calls, and billed miles reported on the demographics tab are displayed in cells B10, B20 and B30. Note: in order to provide you with an example, we have used 500 emergency trips, 200 non-emergency trips and 9,000 billable miles. When you open this sheet, the numbers you entered on the demographics page will be displayed.

In order to use this sheet, you will need to ask your billing clerk or billing company what your average percentage of collections are. If you bill \$100,000 annually and collect \$70,000, then your collection percentage is 70 percent. We'll use this as an example. In this example, if you bill a \$250 base rate for your 500 emergencies, you would collect roughly the amount in cell C14 (\$87,500). For 200 non-emergencies charged at a \$250 base rate you would collect the amount in cell C24 (\$35,000). For 9,000 billed miles at \$9 per mile, you would collect the amount in cell C34 (\$56,700). Your total collections for 500 emergencies, 200 non-emergencies and 9,000 billed miles would be \$179,200.

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.



You can use this sheet to test various rates and collection percentages. We have provided space for you to add these three collections amounts on the Budget Model Worksheet.

If you need to adjust the rates up or down for any or each of the categories, simply change the numbers in cells C10, C20 and C30. Each column D through M on row 10 increases the base rate by \$50. If you want to see what a base rate of \$100 would collect, change C10 to \$100. Then D10 will automatically convert to \$150, E10 to \$200 and so on.

STOP – IT IS TIME TO SAVE YOUR WORK. Click on File and then Save.

Congratulations! You have finished your own budget based on the Budget Model. We would appreciate hearing from you about your experience using this tool, what you did with it when you were finished, and ways we can enhance it in the future. To provide comments, please e-mail info@remsttac.org or telephone us at (866) 587-6370.

Unless you plan to use QuickBooks® and want to import the Chart of Accounts and your budget, you're finished with this tool. Importing into QuickBooks® will be covered in the next section. Printing costs for the QuickBooks® Pro Edition ranged from \$199.95 to \$399.95 at the time this document was printed.

Whether or not you export your data to QuickBooks® you have taken a very important step in planning for the financial future of your Agency. By exporting your data to QuickBooks® or another off-the-shelf accounting software system, you will be able to follow the financial performance of your ambulance service on a monthly basis. Tracking expenditures and revenues monthly better enables you to anticipate future needs and plan for addressing them. Maintaining a detailed budget will also provide you with persuasive data to share with others when you need to demonstrate the value and needs of your ambulance service.



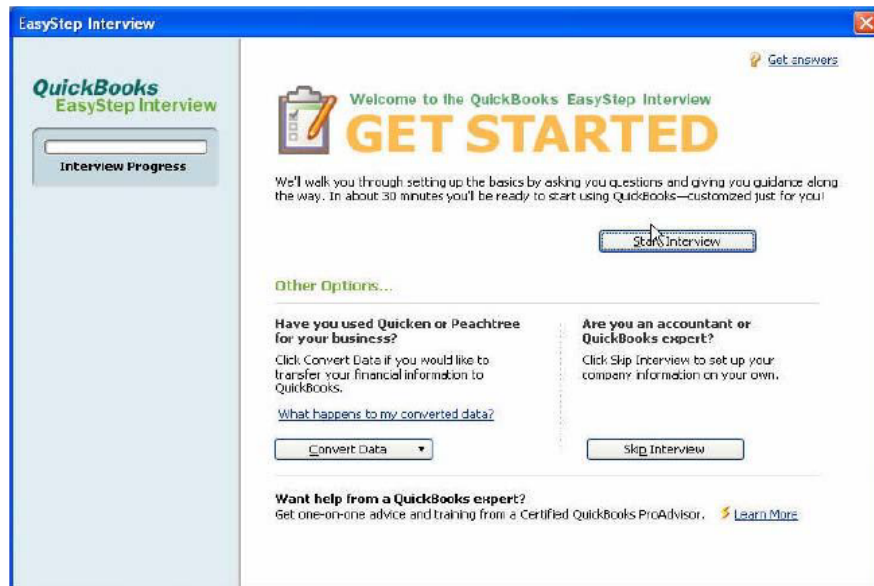
QUICKBOOKS EASY STEP INTERVIEW

There is one tab in the Budget Model that you haven't used yet. This tab contains the and budget information you've just completed, which can be imported into QuickBooks®. This information is formatted for QuickBooks® Pro 2006. Whether it will import into other versions of QuickBooks® is unknown.

We will provide you with a step by step example of importing this data that assumes you just purchased QuickBooks® and are starting from scratch.

After installing QuickBooks®, start the program. Follow the prompts in the program.

You will see the following screen.

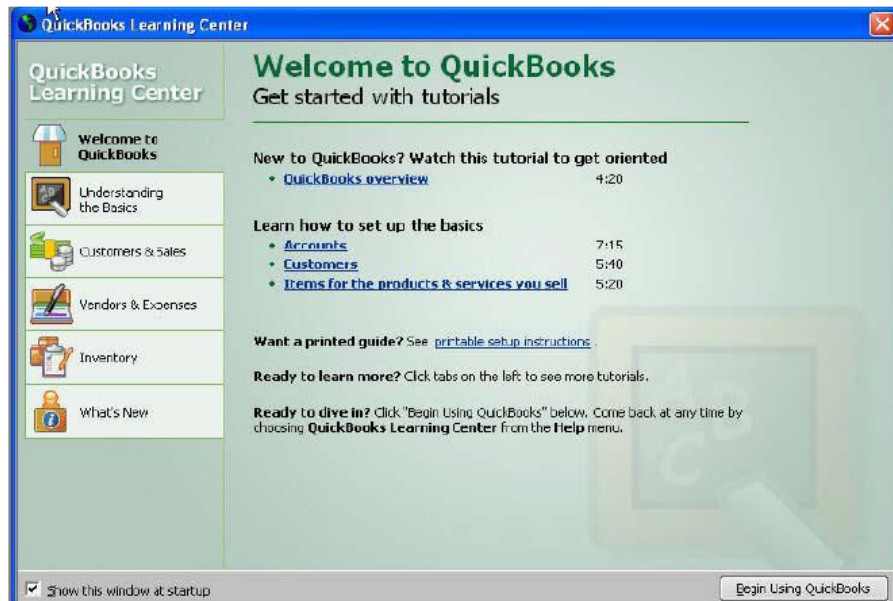


Fill in the appropriate information and click Next.



Select “(No Type)” on the left side and click Next.

Choose either the default place to save your file or another location on your hard drive and click save.



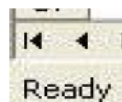
Click “Begin Using QuickBooks” in the lower right corner.

If some Alerts pop up, click “Mark As Done” or “Remind Me Again” if you want to be reminded.

Now go back to your Budget Model spreadsheet. You’ll see this in the lower left corner of the sheet:

29	Mileage		Charge	If you change the number in green, the ot			
30	Loaded Miles	9000	\$ 9.00	\$ 9.50	\$ 10.00	\$ 10.50	\$
31	Collections at	100%	\$ 81,000	\$ 85,500	\$ 90,000	\$ 94,500	\$
32	Collections at	90%	\$ 72,900	\$ 76,950	\$ 81,000	\$ 85,050	\$
33	Collections at	80%	\$ 64,800	\$ 68,400	\$ 72,000	\$ 75,600	\$
34	Collections at	70%	\$ 56,700	\$ 59,850	\$ 63,000	\$ 66,150	\$
35	Collections at	60%	\$ 48,600	\$ 51,300	\$ 54,000	\$ 56,700	\$
36	Collections at	50%	\$ 40,500	\$ 42,750	\$ 45,000	\$ 47,250	\$
37	Collections at	40%	\$ 32,400	\$ 34,200	\$ 36,000	\$ 37,800	\$
◀ ▶ ⏪ ⏩ Building Other Capital Staffing Training Other Expenses Budget Rate Study							

Just above where it says “Ready” click the first arrow on the left side.





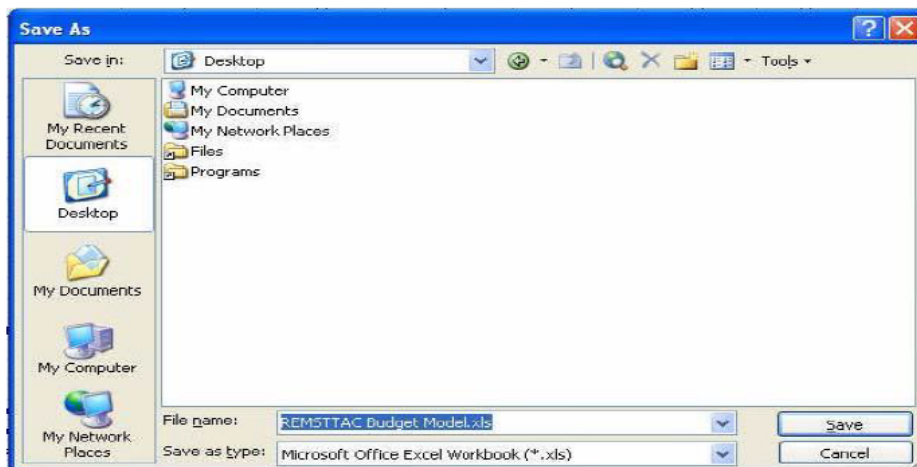
Then you will see the first few tabs in the spreadsheet.



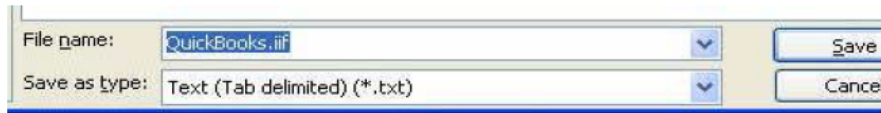
Click on the QuickBooks tab, and you should see this:

	A1		IHDR							
	A	B	C	D	E	F	G	H	I	J
1	IHDR	PROD	VER	REL	IFVER	DATE	TIME	ACCNTNT	ACC	
2	HDR	QuickBooks Pro	Version 16.00	Release R3P	1	12/30/2005	1135985417	N		
3	IACCNT	NAME	REFNUM	TIMESTAMP	ACCNTTYPE	OBAMOUNT	DESC	ACCNUM	SCD	
4	ACCNT	Accounts Receivable	6	1135983967	AR	0		1200		
5	ACCNT	Cash	5	1135983863	OCASSET	0		1000		
6	ACCNT	Prepaid Expenses	7	1135984026	OCASSET	0		1300		
7	ACCNT	Investments	9	1135984079	OCASSET	0		1500		
8	ACCNT	Other Assets	11	1135984122	OCASSET	0		1700		
9	ACCNT	Property, Plant & Equipment	10	1135984108	FMASSET	0		1600		
10	ACCNT	Inventory	8	1135984055	OASSET	0		1400		
11	ACCNT	Accounts Payable	12	1135984154	AP	0		2000		
12	ACCNT	Payroll Liabilities	3	1135985540	OCLIAB	0		2100		
13	ACCNT	Short Term Debt	13	1135984271	OCLIAB	0		2200		

We need to save this tab in a format that QuickBooks can recognize. To do that, we're going to save a duplicate of your budget model under a different name and format.



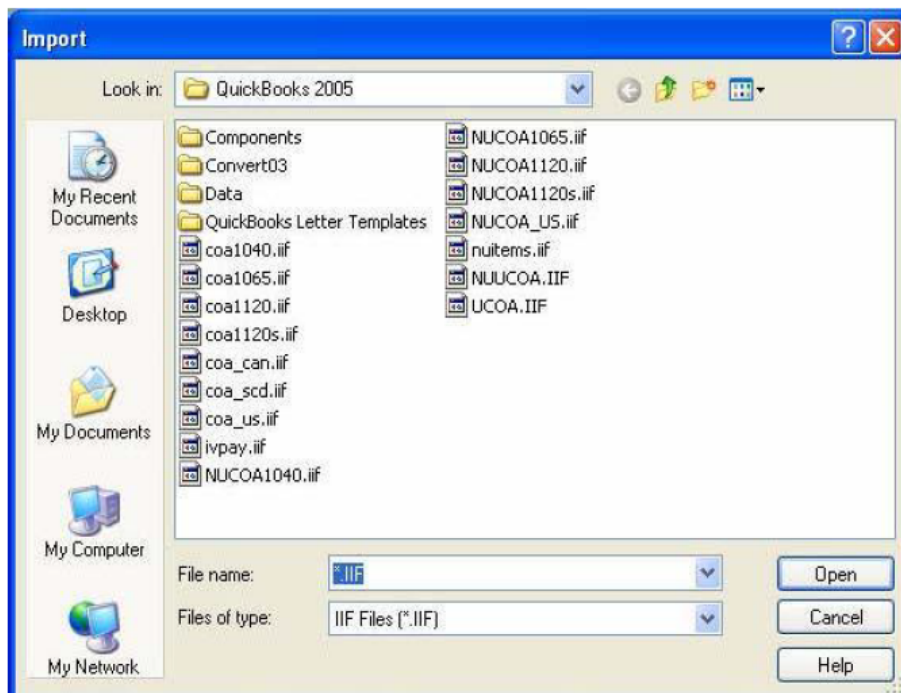
Now change the "Save as type" in the center on the bottom to TEXT. Also, rename the file to QuickBooks.iif.



Now click Save. You may now see two dialogue boxes, one informing you that only the current sheet can be saved and the other that some features of Excel may not be available in this format. Click YES to both dialogue boxes.

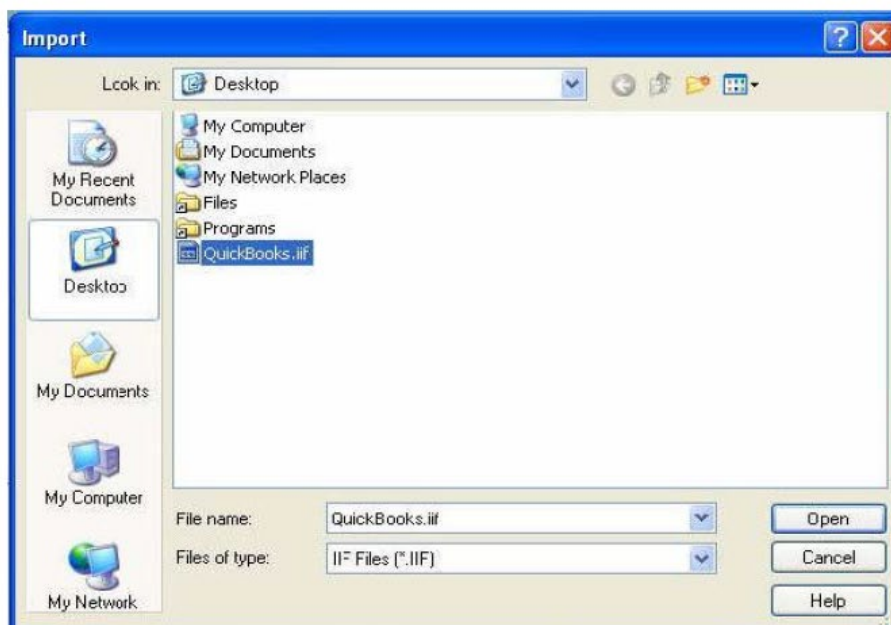
Back to QuickBooks.

Click on File, then Utilities, then Import, then IIF files.

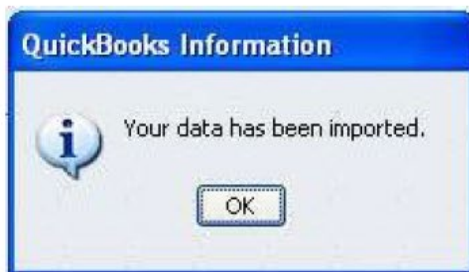




Now click on Desktop on the left and select the QuickBooks.iif file you previously saved.



Click Open. After the budget is imported you will see the following:





Contact REMSTTAC:

Congratulations! You are finished with this tutorial. Please refer to the extensive in-product and on-line support for QuickBooks.

Thank you for using the budget model. We're interested in your feedback on the use and utility of this product. If you have comments or suggestions for improvement, please contact us at:

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APPENDIX A: REMSTTAC STAKEHOLDERS GROUP

Jane Ball, Executive Director
EMSC National Resource Center
Trauma-EMS Technical Assistance
Center

Eli Briggs, Policy & State Affairs
Manager
National Rural Health Association
Government Affairs Office

Bethany Cummings
Rural Affairs Ad Hoc Committee
National Association of EMS Physicians

Drew Dawson, Chief, EMS Division
National Highway Traffic Safety
Administration

Tom Esposito, Medical Director
Rural EMS and Trauma Technical
Assistance Center
Loyola University Medical Center

Blanca Fuentes, Project Officer
Department of Health and Human
Services
Health Resources and Services
Administration
Office of Rural Health Policy

Grant Gray, Representative
National Association of Emergency
Medical Technicians

Christian L. Hanna, Rural Site Director
Children's Safety Network
National Children's Center for Rural
Agricultural Health and Safety

Bob Heath, EMS Education Coordinator
Nevada State Health Division

Marilyn Jarvis, Assistant Director for
Continuing Education
Burns Telecommunications Center
Montana State University

Doug Kupas
Rural Affairs Ad Hoc Committee
National Association of EMS Physicians

Fergus Laughridge, Program Manager
Nevada State Health Division
EMS Bureau of Licensure &
Certification

Tami Lichtenberg, Program Manager
Technical Assistance and Services
Center
Rural Health Resource Center

Patrick Malone, Director
Initiative for Rural Emergency Medical
Services
University of Vermont

N. Clay Mann, Professor, Associate
Director of Research
Intermountain Injury Control Research
Center
University of Utah

Evan Mayfield, CDC Public Health
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Charity Moore, Research Assistant
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University of North Carolina at Chapel
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Carol Miller, Executive Director
Frontier Education Center
National Clearinghouse for Frontier
Communities

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Rural Ambulance Service Budget Model

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328 Innovation Blvd, Suite 222
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Davis Patterson, Research Associate
WWAMI Center for Health Workforce
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University of Washington

Kristine Sande, Project Director
Rural Assistance Center

Dan Summers, Director of Education
Center for Rural Emergency Medicine
West Virginia University

Chris Tilden, Interim Director
Kansas Department of Health &
Environment
Office of Local & Rural Health

Robert K. Waddell II, Secretary
/Treasurer
National Association of EMS Educators

Bill White, President
National Native American EMS
Association

Gary Wingrove, Program Development
Technical Assistance and Services
Center
Rural Health Resource Center

Jill Zabel, Healthcare Consulting
Wipfli LLP



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Appendix F – EMS Call Information Data Displays



Data Interpretation

The data presented in this report should be interpreted within the context of several important limitations and variability factors inherent in multi-agency, multi-jurisdictional EMS systems.

First, all data was provided at the county level, with each county 911 center reporting information for EMS agencies operating within its geographic boundaries. As a result, the dataset reflects how activity is captured and reported within each individual county, rather than a single standardized methodology applied across the study area. Variations in computer-aided dispatch (CAD) systems, data definitions, coding practices, and reporting protocols can influence how incidents, unit statuses, response times, and mutual aid activity are recorded. These differences may affect comparability between counties and should be considered when interpreting cross-jurisdictional trends.

Second, unit availability and status reporting practices vary across EMS agencies. Not all agencies consistently or in real time communicate their availability to 911 centers. In some cases, agencies may delay updating their status until units have returned to their primary service area or are in close proximity. This practice can result in periods where units are operationally available but not reflected as such in the data. Conversely, units may appear unavailable for longer durations than actual service delivery would suggest. These factors can influence measures related to unit hour utilization, coverage availability, and system capacity.

Additionally, agency participation in data reporting may not be uniform. Differences in reporting completeness, timeliness, and accuracy can introduce variability. As a result, certain metrics may be more reflective of reporting practices than strictly operational performance.

Geographic and operational considerations also play a role. EMS systems frequently operate across jurisdictional boundaries, particularly through mutual aid. However, because data are captured within county systems, there may be inconsistencies in how cross-border responses are recorded, attributed, or documented.

It is also important to recognize that call handling and incident classification practices may differ among 911 centers within the studied region. While there are policies governing consistency applications across two thirds of the region, individual interpretation may account for certain variances in call triage protocols, priority assignment, and determinant coding can influence how call volume and acuity are represented. Consequently, comparisons of call types or priority levels across counties should be made with caution.

Finally, the data represents a snapshot in time and may be influenced by temporal factors such as seasonal demand fluctuations, workforce availability, hospital offload delays, or atypical surge



events. These dynamics can affect system performance and resource utilization in ways that may not be fully captured in aggregated datasets.

Taken together, these factors do not diminish the value of the data but rather underscore the importance of interpreting findings within the appropriate operational and data context. The analysis is best viewed as directional and indicative of system patterns, rather than a precise, uniform measurement of performance across all participating entities.

Explanation of “Did Not Crew” Data

The term “Did Not Crew” refers to emergency medical service (EMS) calls where the dispatched EMS agency was unable to respond with a crew. This information is presented in two separate columns for clarity:

- Calls out of ESZ not crewed
- Did not crew rate in ESZ

ESZ stands for Emergency Service Zone. It is the specific geographic area for which an EMS agency (or agencies) has primary responsibility to respond as the first-due provider.

An ESZ is not the same as municipal boundaries. It may cover one municipality, multiple municipalities, or only portions of them, based on how local governments have assigned emergency response responsibilities.

A “Did Not Crew” incident occurs when an EMS agency is dispatched to a call for service but does not respond to cover that call.

For this study, MCM used Geographic Information Systems (GIS) to map every call for service and determine whether it occurred inside or outside the responsible agency’s ESZ. Calls were then separated into two distinct categories:

- Calls inside the ESZ (primary response area)
- Calls outside the ESZ

Only calls dispatched to the primary EMS agency within its own ESZ are used to calculate the “Did Not Crew” rate. This provides the most accurate measure of how reliably the primary responsible agency is able to respond to calls in the area it is assigned to serve.

Secondary and Tertiary Responses

When the primary EMS agency cannot crew a call in its ESZ, the Public Safety Answering Point (PSAP) computer-aided dispatch (CAD) system automatically follows a pre-established station



order. This order identifies the next available (secondary or tertiary) EMS agency to be dispatched.

If a secondary or tertiary agency is dispatched for a call outside its own primary ESZ and does not respond, that incident is not counted in the overall “Did Not Crew” rate. There are many legitimate reasons this may occur, for example, the original primary agency may have become available again and taken the call, or the secondary agency may already be busy on another emergency.



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Appendix F1 – Cameron County Data Displays



Cameron County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
Emporium EMS	12A721 – 1,516	12A721 – 1,852:25:30	2,569	0:05:02	0:06:06	0:11:00	0:36:32	0:43:31	1:21:47	187	48	7.28%
	12A723 – 943	12A726 – 1,124:32:41										
	12STA720 – 110	12STA720 – 0:00:00										
	12A1621 – 41	12A1621 – 88:47:21										
Sinnemahoning EMS	12EMS16 – 142	12EMS16 – 0:05:33	183	0:27:10	0:05:09	0:16:00	1:06:02	1:44:10	2:46:39	144	6	78.70%
Averages/Totals for County:			2,752	0:16:06	0:05:37	0:13:30	0:51:17	1:13:51	2:04:13	331	54	12.03%



Cameron County Call Type Counts per Agency			
Call Type	Agency Counts		
	Emporium EMS	Sinnemahoning EMS	Tall Call Type Counts
>New Call<	2	1	3
24 Other	3	1	4
911 Hangup	4	0	4
Abdominal Pain Alpha	38	1	39
Abdominal Pain Charlie	36	0	36
Abdominal Pain Delta	3	1	4
Administrative Alpha	1	0	1
Alarms Co Without Pt	1	0	1
Allergies Envenimations Stings Bites Alpha	7	0	7
Allergies Envenimations Stings Bites Bravo	2	0	2
Allergies Envenimations Stings Bites Charlie	14	1	15
Allergies Envenimations Stings Bites Delta	11	1	12
Animal Bites Attacks Alpha	5	0	5
Animal Bites Attacks Bravo	4	0	4
Asap To Psap Fire Bravo	7	0	7
Asap To Psap Fire Charlie	3	0	3
Asap To Psap Medical Bravo	12	0	12
Assault / Sexual Assault Bravo	2	0	2
Assault / Sexual Assault Ems Alpha	2	0	2
Assault / Sexual Assault Ems Bravo	2	0	2
Assault / Sexual Assault Ems Delta	1	0	1
Assault/Sexual Assault Charlie 1 Shooting Just Occurred	1	0	1
Back Pain Alpha	22	2	24
Back Pain Charlie	12	0	12
Back Pain Delta	3	0	3
Backcountry Rescue Bravo	1	1	2
Breathing Problems Charlie	66	2	68
Breathing Problems Delta	207	6	213
Breathing Problems Echo	7	1	8
Burns Scalds Explosion Blast Alpha	1	0	1
Carbon Monoxide/Inhale/Hazmat/Cbrn Bravo	2	1	3
Carbon Monoxide/Inhale/Hazmat/Cbrn Delta	2	0	2
Cardiac/Respiratory Arrest/Death Bravo	7	3	10
Cardiac/Respiratory Arrest/Death Delta	3	0	3



Cameron County Call Type Counts per Agency			
Call Type	Agency Counts		
	Emporium EMS	Sinnemahoning EMS	Tall Call Type Counts
Cardiac/Respiratory Arrest/Death Echo	16	1	17
Cardiac/Respiratory Arrest/Death Omega	1	0	1
Expected Death			
Chest Pain Alpha	4	1	5
Chest Pain Charlie	58	1	59
Chest Pain Delta	113	5	118
Choking Alpha	2	0	2
Choking Delta	2	0	2
Choking Echo	3	0	3
Confined Space/Structure Collapse Delta	1	0	1
Convulsions/Seizures Alpha	11	0	11
Convulsions/Seizures Bravo	6	0	6
Convulsions/Seizures Charlie	19	2	21
Convulsions/Seizures Delta	17	0	17
Deceased Person Bravo	1	0	1
Diabetic Problems Alpha	14	2	16
Diabetic Problems Charlie	18	2	20
Domestic Bravo	4	0	4
Domestic Delta	2	0	2
Electrical Hazard Alpha	0	1	1
Elevator/Escalator Rescue Bravo	1	0	1
Eye Problems/Injuries	2	0	2
Falls Alpha	195	12	207
Falls Bravo	157	9	166
Falls Charlie	5	0	5
Falls Delta	52	5	57
Fire Alarms Bravo	9	2	11
Fire Alarms Charlie	6	0	6
Headache Alpha	4	0	4
Headache Bravo	1	0	1
Headache Charlie	5	0	5
Heart Problems/Aicd Alpha	2	0	2
Heart Problems/Aicd Charlie	23	0	23
Heart Problems/Aicd Delta	17	1	18
Heat/Cold Exposure Bravo	1	1	2



Cameron County Call Type Counts per Agency			
Call Type	Agency Counts		
	Emporium EMS	Sinnemahoning EMS	Tall Call Type Counts
Heat/Cold Exposure Delta	2	0	2
Hemorrhage/Laceration Alpha	15	0	15
Hemorrhage/Laceration Bravo	42	4	46
Hemorrhage/Laceration Charlie	3	0	3
Hemorrhage/Laceration Delta	28	3	31
Inaccessible Incident	1	0	1
Landing Zone	1	1	2
Launch Emd Proqa	1	0	1
Lost Person Charlie	1	1	2
Mental Disorder (Behavior Problems) Bravo	3	0	3
Mental Disorder (Behavior Problems) Delta	1	0	1
Miscellaneous Bravo	2	0	2
Outside Fire Bravo	1	0	1
Outside Fire Endangering Structure	1	0	1
Overdose/Poisoning Bravo (Ingestion)	5	0	5
Overdose/Poisoning Charlie (Ingestion)	10	3	13
Overdose/Poisoning Delta (Ingestion)	3	0	3
Overdose/Poisoning Echo (Ingestion)	1	0	1
Overdose/Poisoning Omega (Ingestion)	1	0	1
Phone Call	31	2	33
Pregnancy/Childbirth/Miscarriage Bravo	3	0	3
Pregnancy/Childbirth/Miscarriage Charlie	2	0	2
Pregnancy/Childbirth/Miscarriage Delta	8	0	8
Psychiatric/Abnormal Behavior/Suicide Attempt Alpha	20	1	21
Psychiatric/Abnormal Behavior/Suicide Attempt Bravo	12	1	13
Psychiatric/Abnormal Behavior/Suicide Attempt Charlie	15	0	15
Psychiatric/Abnormal Behavior/Suicide Attempt Delta	4	0	4
Psychiatric/Abnormal Behavior/Suicide Attempt Omega	2	0	2
Public Service Alpha	25	6	31
Public Service Bravo	3	1	4
Public Service Delta	1	0	1



Cameron County Call Type Counts per Agency			
Call Type	Agency Counts		
	Emporium EMS	Sinnemahoning EMS	Tall Call Type Counts
Service Call Alpha	1	0	1
Sick Person Alpha	279	22	301
Sick Person Bravo	15	2	17
Sick Person Charlie	112	12	124
Sick Person Delta	30	1	31
Stab/Gunshot/Penetrating Trauma Bravo	1	0	1
Stab/Gunshot/Penetrating Trauma Delta	3	0	3
Stroke (Cva)/Transient Ischemic Attack (Tia)	64	8	72
Struct Fire Com / Indust	2	0	2
Struct Fire Echo 5 Multi Resid	2	0	2
Struct Fire Echo 6 Single Res	11	1	12
Struct Fire Echo 9 Mobile Home	2	2	4
Struct Fire Entrapment	2	0	2
Struct Fire High Life	2	0	2
Struct Fire Lg Non-Dwell	1	0	1
Struct Fire Mobile Home	1	1	2
Struct Fire Multi Res	2	1	3
Struct Fire Single Res	8	0	8
Suicidal Person/Attempt Suicide	2	0	2
Suicidal Person/Attempt Suicide	3	0	3
Suspicious/Wanted Charlie	1	0	1
Test, Test, Test	2	0	2
Traffic Collision/Trans Incident Bravo	1	0	1
Traffic Collision/Trans Incident Charlie	1	0	1
Traffic/Transportation Accident Bravo	11	2	13
Traffic/Transportation Accident Delta	1	0	1
Traffic/Transportation Incident Alpha	5	2	7
Traffic/Transportation Incident Bravo	17	6	23
Traffic/Transportation Incident Bravo Unknown	17	5	22
Traffic/Transportation Incident Delta	4	1	5
Traffic/Transportation Incident Delta High Mechanism	19	3	22
Traffic/Transportation Incident Delta Major Incident	1	0	1



Cameron County Call Type Counts per Agency			
Call Type	Agency Counts		
	Emporium EMS	Sinnemahoning EMS	Tall Call Type Counts
Traffic/Transportation Incident Delta Pedestrian Struck	2	0	2
Traffic/Transportation Incident Delta Pinned	2	1	3
Traffic Violation/Complaint/Hazard Alpha	0	1	1
Traffic Violation/Complaint/Hazard Charlie	0	1	1
Transfer/Interfacility Alpha	16	0	16
Transfer/Interfacility Charlie	27	0	27
Transfer/Interfacility Charlie 1	20	0	20
Transfer/Interfacility Delta	1	0	1
Transport	96	1	97
Traumatic Injuries Alpha	24	1	25
Traumatic Injuries Bravo	14	2	16
Traumatic Injuries Delta	9	2	11
Unconscious/Fainting Alpha	31	2	33
Unconscious/Fainting Charlie	42	3	45
Unconscious/Fainting Delta	62	6	68
Unknown Problem Bravo	81	4	85
Unknown Problem Delta	1	0	1
Vehicle Fire Bravo	1	0	1
Vehicle Fire Delta Threat Struct	1	0	1
Water/Ice/Mud Recue Delta Swift Water - 72	1	0	1
Water/Ice/Mud Rescue Bravo	1	0	1
Total Call Counts:	2,569	183	2,752

The Cameron County EMS dataset, representing 36 months of activity from 2023 through 2025, provides a clear picture of system performance across both high-volume and low-volume rural providers. The county responded to a total of 2,752 calls during this period, with an overall average call time of approximately two hours and four minutes and a system-wide “did not crew” rate of just over 12 percent. These figures reflect a system operating under typical rural EMS conditions, characterized by extended response cycles, variability in staffing availability, and significant demands on limited resources.

When examining response performance, the most notable issue appears in turnout time, or the interval from dispatch to enroute. The county average for this interval is just over 16 minutes;



however, this masks substantial variation between agencies. Emporium EMS demonstrates a relatively strong turnout time of approximately five minutes, which is consistent with expectations for a volunteer or combination system. In contrast, Sinnemahoning EMS data shows an average turnout time exceeding 27 minutes, which is significantly above both national rural norms and accepted operational benchmarks. Even in rural systems, turnout times are generally expected to fall within a range of five to ten minutes. This indicates that the overall county average is largely driven by staffing and availability challenges rather than geographic constraints. Such prolonged turnout times suggest issues related to volunteer response, crew assembly, or alerting processes, and represent a critical area for improvement.

In contrast, travel times from enroute to arrival appear efficient and consistent with rural expectations. The county's average travel time is approximately five minutes and thirty-seven seconds, indicating relatively favorable station placement or manageable geographic coverage areas. As a result, the overall dispatch-to-arrival response time averages approximately thirteen and a half minutes, which falls within the acceptable range for rural EMS systems. While this performance is reasonable when compared to national rural benchmarks, it is important to note that response effectiveness is being limited by delays in crew activation rather than travel inefficiencies. In other words, once units are enroute, they perform efficiently, but delays in becoming enroute hinder overall system responsiveness.

On-scene times are not explicitly isolated in the dataset; however, they can be inferred from the broader time distribution. Given the nature of the call types, most notably falls, breathing problems, chest pain, and general illness, moderate on-scene times are expected. These types of calls often require patient assessment, stabilization, and packaging prior to transport. While it is likely that on-scene times are within a reasonable range, they may be slightly elevated due to limited staffing levels, increased reliance on basic life support crews, or the complexity of the patient population, which in rural areas often includes a higher proportion of elderly individuals with chronic conditions.

Transport times in Cameron County present a different pattern, reflecting the unavoidable realities of rural healthcare access. The county average transport time is approximately fifty-one minutes, which is substantially higher than urban EMS systems but consistent with rural norms, where transport times frequently range from twenty to sixty minutes or more depending on hospital proximity and service availability. This extended transport duration is not indicative of inefficiency but rather highlights the structural challenges associated with geographic isolation and limited healthcare infrastructure. However, it does contribute significantly to overall unit commitment time, reducing availability for subsequent calls and increasing the strain on system resources.



The most critical inefficiency identified in the dataset is the time spent at the hospital, also referred to as out-of-service time. The county average for hospital time is approximately one hour and fourteen minutes, with Sinnemahoning EMS experiencing even longer durations approaching one hour and forty-four minutes. These figures far exceed national best practice targets, which generally recommend hospital turnaround times of twenty to thirty minutes, with anything exceeding forty-five minutes considered delayed. Extended hospital times are a major operational concern, as they remove units from service for prolonged periods, reduce system capacity, and directly contribute to the observed non-crewed call rate. This bottleneck is particularly impactful in a low-resource rural system, where even the temporary loss of a single unit can significantly degrade coverage.

Several opportunities exist to improve hospital turnaround efficiency. Establishing formal offload agreements between EMS agencies and receiving hospitals could help define expectations and streamline transfer-of-care processes. The implementation of rapid offload protocols, including EMS triage or designated offload areas, may allow crews to transfer patient care more quickly without waiting for full bed assignment. Additionally, improved pre-arrival communication between EMS and hospital staff could facilitate patient readiness upon arrival, reducing delays. Tracking and sharing EMS-to-wall time data with hospital partners on a regular basis would also create transparency and accountability, encouraging system-wide improvements in throughput.

Beyond hospital operations, additional strategies can be considered to strengthen system performance. Reducing turnout times should be a priority, potentially through the use of scheduled duty crews, part-time staffing models, or incentives to improve volunteer response reliability. Addressing the 12 percent non-crewed call rate will require a combination of regional coordination, staffing enhancements, and possibly shared service models. Increasing collaboration between agencies, including cross-coverage agreements and resource sharing, could help mitigate coverage gaps, particularly for low-volume areas such as Sinnemahoning.

From a system-wide perspective, the call type distribution suggests opportunities to reduce demand through targeted community interventions. High-frequency call types such as falls, breathing problems, and general illness could be addressed through community paramedicine programs, fall prevention initiatives, and chronic disease management support. These approaches align with both Pennsylvania EMS priorities and national trends in mobile integrated healthcare, which aim to reduce unnecessary 911 utilization and improve patient outcomes through proactive care.



In summary, the Cameron County EMS system demonstrates several strengths, particularly in travel efficiency and overall response time within a rural context. However, these strengths are offset by significant challenges, including prolonged turnout times, excessive hospital turnaround times, and a high rate of unstaffed responses. The most impactful opportunities for improvement lie in reducing hospital delays, strengthening staffing models, and enhancing regional coordination. By addressing these areas, the system can improve responsiveness, increase availability, and better meet the needs of the communities it serves.



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Appendix F2 – Clearfield County Data Displays



Clearfield County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
Amserv/ Dusan EMS	174351- 1,394	174351 – 1,233:53:39	15,521	0:04:55	0:08:39	0:13:17	0:09:57	0:28:58	0:54:06	186	185	1.20%
	174352 – 4,843	174352 – 4,263:34:17										
	174353 – 3,823	174353 – 3,601:44:40										
	174354 – 3,083	174354 – 3,050:07:13										
	174355 – 2,116	174355 – 2,068:14:26										
	174356 – 2	174356 – 0:19:43										
	17IN43 – 47	17IN43 – 109:47:55										
	17MD43 – 1	17MD43 – 1:44:02										
	17MEDCOM 431 – 4	17MEDCOM43 1 – 28:35:30										
	17MEDCOM 432 – 3	17MEDCOM43 2 – 36:39:27										
	17RGR43 – 1	17RGR43 – 6:44:51										
	17STA43 - 204	17STA43 – 2:14:32										
Brady Township EMS	173050 – 49	173050 – 49:37:32	895	0:10:34	0:06:08	0:16:24	0:13:53	0:24:25	0:57:24	358	34	40.00%
	173051 – 782	173051 – 396:42:45										



Clearfield County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
Clearfield EMS	17QRS30 – 13	17QRS30 – 5:08:28	14,167	0:04:34	0:07:24	0:11:38	0:12:18	0:24:34	0:52:12	236	139	1.67%
	17STA30 – 51	17STA30 – 0:05:05										
	17151 – 3,630	17151 – 2,377:51:05										
	17152 – 3,071	1,945:14:20										
	17153 – 1,767	17153 – 1,021:20:59										
	17154 – 2,057	17154 – 1,189:59:18										
	17155 – 2,441	17155 – 1,515:23:52										
	17156 – 1,039	336:36:06										
	17IN1 – 4	17IN1 – 6:04:06										
	17STA1 – 158	17STA1 – 0:00:00										
Curwensville Rescue Hose and Ladder EMS	17850 – 57	17850 – 54:19:17	6,020	0:06:16	0:06:50	0:12:46	0:22:23	0:36:27	1:08:36	76	161	1.26%
	17851 – 446	17851 – 136:28:16										
	17852 – 1,183	674:59:48										
	17853 – 1,627	17853 – 875:58:43										
	17854 – 2,480	17854 – 2,046:21:41										



Clearfield County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
	17CART8 – 8	17CART8 – 113:57:36										
	17MCU8 – 13	17MCU8 – 11:03:53										
	17MEDCOM 8 – 127	17MEDCOM8 – 330:20:40										
	17QRS8 – 6	17QRS8 – 0:55:31										
	17QRS8-2 – 1	17QRS8-2 – 0:00:43										
	17QRS8-4 – 6	17QRS8-4 – 2:34:51										
	17STA8 – 66	17STA8 – 1:15:03										
	174751 – 1,437	174751 – 2,072:17:48										
Houtzdale Ramey EMS	174752 – 1	174752 – 0:00:00	1,591	0:08:27	0:05:13	0:13:28	0:35:02	0:51:23	1:31:30	207	25	13.01%
	17STA47 – 153	17STA47 – 0:00:52	1,150	0:10:13	0:07:38	0:17:28	0:35:53	1:38:59	2:14:17	188	22	16.35%
	172751 – 1,037	172751 – 2,103:52:25										
Irvona EMS	17STA27 – 113	17STA27 – 0:00:00										
Karthus EMS	172050 – 9	172050 – 9:48:40	444	0:14:09	0:09:24	0:21:20	0:43:13	0:40:33	1:35:20	169	21	38.06%
	172051 – 292	172051 – 402:28:52										
	17CEQRS17 – 32	17CEQRS17 – 4:24:02										



Clearfield County EMS – 36 Month Data (2023-2025)											
Agencies	Calls Dispatched per Unit	Total Committed Time per unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Did not crew Rate in ESZ
Madera EMS	17STA20 – 111	17STA20 – 1:10:36	999	0:06:56	0:07:27	0:14:07	0:35:44	0:53:55	1:35:10	78	7.81%
	172551 – 529	172551 – 660:33:21									
	172552 – 442	172552 – 732:02:49									
	17STA25 – 28	17STA25 – 0:01:30									
Mahaffey EMS	172951 – 116	172951 – 93:44:11	438	0:11:06	0:07:06	0:17:51	0:34:20	1:00:52	1:37:42	152	34.70%
	172952 – 225	172952 – 352:25:19									
	17STA29 – 97	17STA29 – 0:00:00									
Averages/Totals for County:		5,438:54:35	41,225	0:08:34	0:07:19	0:15:22	0:26:58	0:46:41	1:22:55	1,650	4.00%



Clearfield County Call Type Counts per EMS Agency											
Call Type	EMS Agencies										
	Amersy/Dusan EMS	Brady Twp EMS	Clearfield EMS	Curwensville EMS	Houtsdale Ramsey EMS	Invena EMS	Karthus EMS	Madera EMS	Mahaffey EMS	Total Call Count by Type	
>New Calls	2		7	6			1			16	
20 Limited Fire Service	1									1	
Abdominal Pain Alpha	265	13	120	50	26	21	6	16	6	523	
Abdominal Pain Charlie	197	9	109	43	23	22	3	19	2	427	
Abdominal Pain Delta	53	3	21	8	3	1	1	1		91	
Administrative Alpha	1		1							2	
Alarms Co Without Pt	8			1						9	
Alarms Delta	1									1	
Allergies Envenomations Stings Bites Alpha	19	1	16	6	1	3	1	1	1	49	
Allergies Envenomations Stings Bites Bravo	5		5	3	2	1		1		17	
Allergies Envenomations Stings Bites Charlie	32		15	5	4	4	3	4		67	
Allergies Envenomations Stings Bites Delta	51	1	24	5	3	3	2	2		91	
Animal Bites Attacks Alpha	4		6							10	
Animal Bites Attacks Bravo	2			3	1					6	
Animal Bites Attacks Delta	5	1	1	2						9	
Assault / Sexual Assault Bravo	10	1	4	1	1					17	
Assault / Sexual Assault Delta	1		2							2	
Assault / Sexual Assault Ems Alpha	17	2	15	4	1	3	1	1		44	
Assault / Sexual Assault Ems Bravo	24		16	2	8	1			1	52	
Assault / Sexual Assault Ems Delta	4		6		2		1			13	
Assault Pd Only			1							1	
Assault/Sexual Assault Charlie	4		4	1						9	
Assault/Sexual Assault Charlie 1 Shooting Just Occurred			2							2	
Assist Other Agencies Bravo	21		10	2						33	
Assist Other Agencies Delta			2							2	
Back Pain Alpha	128	6	75	38	17	15	4	8	3	294	
Back Pain Charlie	61	3	49	18	3	4		5	3	146	
Back Pain Delta	15		5	3						23	
Backcountry Rescue Delta			1							1	
Backcountry Rescue Bravo					1		1			2	
Backcountry Rescue Charlie				1			1			2	
Bomb Threat Bravo			1							1	
Break in Bravo			1							1	
Break in Charlie	2									2	
Breathing Problems Charlie	339	20	213	60	30	28	9	16	10	725	
Breathing Problems Delta	1,223	60	681	266	118	83	27	78	30	2,566	
Breathing Problems Echo			5	2						7	
Burns Explosion Alpha Fire Alarm	1		1							2	
Burns Scalds Explosion Blast Alpha	5		4	2	1					12	
Burns Scalds Explosion Blast Bravo				2					1	3	
Burns Scalds Explosion Blast Charlie	2		1	1		1	1			5	
Burns Scalds Explosion Blast Delta	2			1		1				4	
Carbon Monoxide/Inhalation/Hazmat/Cbrn Charlie	3		2	1			1			7	
Carbon Monoxide/Inhalation/Hazmat/Cbrn Omega	3									3	
Carbon Monoxide/Inhalation/Hazmat/Cbrn Bravo	7	1	2		1		1	1	1	13	
Carbon Monoxide/Inhalation/Hazmat/Cbrn Delta				1						8	
Cardiac/Respiratory Arrest/Death Bravo	39	5	36	12	14	8	1	4	1	120	
Cardiac/Respiratory Arrest/Death Delta	31	2	15	4	1	2				55	
Cardiac/Respiratory Arrest/Death Echo	149	4	96	26	20	22	3	9	3	332	
Cardiac/Respiratory Arrest/Death Echo 3 Hanging	10		5		3		2			20	
Cardiac/Respiratory Arrest/Death Omega Expected Death	2		8		2	1		1		14	
Chest Pain Alpha	27	1	14	1	2	5	1	2		53	



Call Type	Clearfield County Call Type Counts per EMS Agency															Total Call Count by Type
	Amsery/Duan EMS	Brady Twp EMS	Clearfield EMS	Curwensville EMS	Houtsdale Ramsey EMS	Inyona EMS	Karthus EMS	Madera EMS	Mahaffey EMS	EMS Agencies						
	279	9	128		43	50	20	18	5							562
Chest Pain Charlie	1			1			1	1					1			4
Chest Pain Charlie Cocaine	726	28	329	136		77	59	18	34				47			1,434
Chest Pain Delta																
Choking Alpha	10		12	3				3					1			26
Choking Delta	41	4	18	6		2	1					1				73
Choking Echo	6	1	2	2			1					1				13
Confined Space/Structure Collapse Bravo																
Confined Space/Structure Collapse Delta			1	2			1									3
Control Burn				1											1	1
Convulsions/Seizures Alpha													1			
Convulsions/Seizures Bravo	56	3	42	11		2	6	2	2				6			130
Convulsions/Seizures Charlie	31		22	10		3		1					1			70
Convulsions/Seizures Delta	101	4	42	19		13	1	3	5					1		189
Convulsions/Seizures Echo																
Convulsions/Seizures Delta	286	7	123	41		21	10	8	35					4		515
Curwensville Ems Department				1				1								1
Deceased Person Bravo	6			2		1	1	1								22
Deceased Person Delta	1	1														2
Diabetic Problems Alpha																
Diabetic Problems Charlie	60	1	29	10		4	10	2					2			118
Diabetic Problems Delta	138	3	86	33		12	16	2	3				3	6		299
Diabetic Problems Echo																
Diabetic Problems Delta	49	1	23	7		4	1	1	2				2	1		89
Disturbance Alpha	5		4	1												10
Disturbance Bravo																
Disturbance Charlie	5		1	2												8
Disturbance Delta				1												1
Disturbance Echo	2		4													6
Domestic Bravo	1		10	1												12
Domestic Charlie																
Domestic Delta	1		2	1												4
Drill / Exercise	4															3
Drowning (Near)/Diving/Scuba Accident Charlie																
Drowning (Near)/Diving/Scuba Accident Charlie	1		1	3		1		2						1		12
Drugs Alpha																1
Dui Bravo	1															1
Dui Charlie			1													2
Dui Delta			1													1
Electrocution/Lightning Charlie																
Electrocution/Lightning Charlie																
Electrocution/Lightning Delta	1															1
Elevator/Escalator Rescue Bravo																
Emerg Medasst																
Ems Standby	8	6	28	12		7	2	1	9				9	2		75
Ems Standby	91	4	111	222		15	5	10	47				47	4		509
Explosion Bravo																1
Explosion Charlie	1			1												1
Extraction/Entrapped Machinery, Veh Delta																
Extraction/Entrapped Machinery, Veh Delta	2		2	1					1				1			6
Extraction/Entrapped Machinery, Veh Alpha																
Extraction/Entrapped Machinery, Veh Bravo																
Extraction/Entrapped Machinery, Veh Charlie	2	2	1	1		1										1
Extraction/Entrapped Machinery, Veh Charlie	1															
Eye Problems/Injuries																
Falls Alpha	12	1	6	2		1	1	2	3				3	1		28
Falls Alpha	1,080	65	885	309		124	70	23	44				44	22		2,622
Falls Bravo	964	50	794	171		67	63	16	28				28	21		2,174
Falls Bravo																
Falls Charlie	44		4	1		2	1		1				1	1		53
Falls Delta	423	21	198	61		30	15	9	17				17	5		779
Falls Delta																
Fire Alarms Bravo	37		21	5		2	8	1	3				3			77
Fire Alarms Charlie																
Fire Alarms Charlie	124		47	15		1	16	1								204
Fire Police	3	2	3	1					1				1	1		11
Fire Police																
Gas Leak/Gas Odor Bravo	3															3
Gas Leak/Gas Odor Charlie	3															4



Call Type	Clearfield County Call Type Counts per EMS Agency													Total Call Count by Type
	Amersy/Duane EMS	Brady Twp EMS	Clearfield EMS	Curwensville EMS	Houtsdale Ramsey EMS	Invoyna EMS	Karthus EMS	Madera EMS	Manahaw EMS	EMS Agencies				
Gas Leak/Gas Odor Delta	5	1	2	1	1								9	
Headache Alpha	23	1	12	1	3	2		1					43	
Headache Bravo	5	1	1	2	2								11	
Headache Charlie	52	1	14	9	4	6		3	1				90	
Heart Problems/Acid Alpha	16	4	11		2								37	
Heart Problems/Acid Charlie	164	12	86	53	43	25	4	11	4				402	
Heart Problems/Acid Delta	192	10	108	49	32	11	7	8	5				422	
Heat/Cold Exposure Alpha	3		1										4	
Heat/Cold Exposure Bravo	1			2									3	
Heat/Cold Exposure Charlie	3		2	1									6	
Heat/Cold Exposure Delta	5			1		1		1					8	
Hemorrhage/Laceration Alpha	49	2	44	14	12	7	2	5	2				137	
Hemorrhage/Laceration Bravo	166	13	146	69	30	13	12	16	8				473	
Hemorrhage/Laceration Charlie	54	3	14	7	1		2						81	
Hemorrhage/Laceration Delta	187	12	140	52	33	16	3	8	4				455	
High Angle Rescue Bravo	1					1	1						3	
High Angle Rescue Delta	1			1									2	
Inaccessible Incident									1				1	
Indecency/Lewdness Bravo	1		1										2	
Information		1											2	
Landing Zone	3	4	6	13	10		5	1	2				44	
Launch End Proqa	1												1	
Lost Person Charlie				1									1	
Medical Assist Fire	93	23	245	138	67	24	15	77	37				719	
Mental Disorder (Behavior Problems) Bravo	2		3										5	
Mental Disorder (Behavior Problems) Charlie			1										1	
Mental Disorder (Behavior Problems) Delta	2		1										3	
Miscellaneous Bravo	1												1	
Missing/Runaway/Found Person Bravo	3												3	
Missing/Runaway/Found Person Charlie	1		1										2	
Mutual Aid Delta	1												1	
Nova Pd Only	2												2	
Meals	9	2	12	3	1	1		1	1				30	
Miscals	3	1	2	1	1			1					9	
Nonemerg Medasst	14	5	32	29	14	5		6	8				113	
Odor Unknown Bravo			1										1	
Ongoing	2												2	
Outside Fire Alpha	1		1	2									4	
Outside Fire Bravo			2	3	1		1						7	
Outside Fire Charlie	2												2	
Outside Fire Delta	2			1									3	
Overdose/Poisoning Bravo (Ingestion)	25	1	12	8	5	1	1	2	1				56	
Overdose/Poisoning Charlie (Ingestion)	83	3	59	17	19	11	5	3	1				201	
Overdose/Poisoning Delta (Ingestion)	43		31	7	5	6	1	3					96	
Overdose/Poisoning Echo (Ingestion)	3		2										5	
Overdose/Poisoning Omega (Ingestion)	10		2	4	1				1				18	
Phone Call	6	3	1	1	1								12	
Pregnancy/Childbirth/Miscarriage Alpha														
Pregnancy/Childbirth/Miscarriage Bravo	2		2	1									6	
Pregnancy/Childbirth/Miscarriage Charlie		1	3		2	1		1					9	
Pregnancy/Childbirth/Miscarriage Delta	8	1	7	1									17	
Pregnancy/Childbirth/Miscarriage Echo	13	1	13	4	3		1	2	1				38	
Psych and Delus	4		7										11	



Clearfield County Call Type Counts per EMS Agency												
Call Type	EMS Agencies											
	Amsery/Duane EMS	Brady Twp EMS	Clearfield EMS	Curwensville EMS	Houttsdale Ramsey EMS	Invoia EMS	Karthus EMS	Madera EMS	Manahaw EMS	Total Call Count by Type		
Psychiatric/Abnormal Behavior/Suicide Attempt Alpha	242	4	128	40	10	22	7	12	4	469		
Psychiatric/Abnormal Behavior/Suicide Attempt Bravo	212	4	121	24	18	11	1	11	4	406		
Psychiatric/Abnormal Behavior/Suicide Attempt Charlie	30		20	1	1					42		
Psychiatric/Abnormal Behavior/Suicide Attempt Delta	108	2	60	4	11	4	1	6		196		
Psychiatric/Abnormal Behavior/Suicide Attempt Omega	1								1	1		
Public Service Alpha	20		25	5				1	1	52		
Public Service Bravo	2		3	1				6	6	6		
Public Service Charlie	1		1							1		
Pursuit	2		1							3		
Robbery Charlie Personal	1									1		
Search Detail	3	2	4	1			1			11		
Service Call Alpha	3		9	14	1		4	6	5	42		
Service Call Alpha Lift Assist	2			1				2		5		
Sick Person Alpha	1,623	97	993	368	141	128	37	89	34	3,510		
Sick Person Bravo	174	7	65	21	15	19	7	5	4	317		
Sick Person Charlie	824	50	565	237	76	58	23	46	27	1,906		
Sick Person Delta	494	20	206	68	26	20	19	17	7	877		
Smoke Investigation Alpha	1									1		
Stab/Gunshot/Penetrating Trauma Alpha	1									1		
Stab/Gunshot/Penetrating Trauma Bravo	2		4	2	1	1			1	11		
Stab/Gunshot/Penetrating Trauma Delta	7	1	8	4	1	1	2		1	25		
Stroke (Cva)/Transient Ischemic Attack (Tia)	337	20	172	78	33	26	10	15	12	703		
Stroke (Tia)/Transient Ischemic Attack (Tia)	1		2			2				5		
Struct Fire Appliance Contained	1									1		
Struct Fire Burned Food			1							1		
Struct Fire Chimney	1	1	1					2		5		
Struct Fire Com / Hazmat				1						1		
Struct Fire Com / Indust	17	2	18	1	3	1	1		1	44		
Struct Fire Echo 13 Unknown	1									1		
Struct Fire Echo 2 High Rise	1									1		
Struct Fire Echo 3 Com/Indust	2		1				1	2		6		
Struct Fire Echo 5 Multi Resid	1									1		
Struct Fire Echo 6 Single Bus	3	1	2	1						7		
Struct Fire Echo 8 Sm Non-Dwell				1						1		
Struct Fire Echo 9 Mobile Home	1							1		2		
Struct Fire Electrical Problem			1	1	2	1		1		6		
Struct Fire Entrapment	1		2	1	1					5		
Struct Fire High Life	3		3							6		
Struct Fire High Rise	3		2							5		
Struct Fire Ig Non-Dwell	5		2	1	2	1	1	2	1	15		
Struct Fire Mobile Home	6		5	1		1	1	2	1	17		
Struct Fire Multi Res	14		11	5			1			31		
Struct Fire Single Bus	67	7	52	24	11	9	4	8	1	183		
Struct Fire Sm Non-Dwell	6	2	3	2	1					14		
Struct Fire Smoke Odor	1		1							2		
Struct Fire Unknown	4		1	3				1		9		
Structure Fire	17	4	10	6	2	1	3	5	3	51		
Suicidal Person/Attempt Suicide	1				1					2		
Suspicious/Wanted Bravo	10		7							17		
Suspicious/Wanted Charlie	1		2							3		
Theft/Larceny Charlie			1							1		
Traffic Collision/Trans Incident Alpha	20	2	22	4	2	4	1	2	1	68		



Clearfield County Call Type Counts per EMS Agency												
Call Type	EMS Agencies											
	Amersy/Duan EMS	Brady/Twp EMS	Clearfield EMS	Cumruville EMS	Houtsdale Ramsey EMS	Inyona EMS	Karthus EMS	Madera EMS	Manaffter EMS	Total Call Count by Type		
Traffic Collision/Trans Incident Bravo	111	16	111	34	11	12	6	13	8	322		
Traffic Collision/Trans Incident Charlie	93	11	73	26	15	14	4	16	9	261		
Traffic Collision/Trans Incident Delta	270	29	197	52	38	33	16	57	13	705		
Traffic Collision/Trans Incident Delta High Mechanism	2	1	7	1					1	12		
Traffic Collision/Trans Incident Delta Multi Vehicle	2	1	2	2		1		1		9		
Traffic Collision/Trans Incident Echo	1		2							3		
Traffic Control	2	2		1	1					4		
Traffic Stop	2		5							7		
Traffic Violation/Complaint/Hazard Alpha	1									1		
Traffic Violation/Complaint/Hazard Bravo								1		1		
Traffic/Transportation Accident Alpha	28		17	3	2	1	1			52		
Traffic/Transportation Accident Bravo	15		10							25		
Traffic/Transportation Accident Charlie	9		1							10		
Traffic/Transportation Accident Delta	4		3					2	1	9		
Traffic/Transportation Incident Alpha	10		9	5		1	1			28		
Traffic/Transportation Incident Bravo	31	1	15	2	1	2	1		3	56		
Traffic/Transportation Incident Bravo Injury Possibly Dangerous	1									1		
Traffic/Transportation Incident Bravo Unknown	19		1							21		
Traffic/Transportation Incident Delta	77	1	11	5	2	3	1	1	4	105		
Traffic/Transportation Incident Delta High Mechanism	6		5		1					12		
Traffic/Transportation Incident Delta Pinned	6		1							7		
Transfer Assignment	1		2	2						5		
Transfer/Interfacility Alpha	172	58	3,669	2124			1	6	8	6,038		
Transfer/Interfacility Charlie	5	2	260	54						321		
Transfer/Interfacility Charlie 1	6	3	222	40						271		
Transfer/Interfacility Delta	5	3	456	84						548		
Transport	3		3	3						9		
Traumatic Injuries Alpha	131	7	56	31	10	9	3	9	2	258		
Traumatic Injuries Bravo	63	1	39	26	9	2	3	6	1	150		
Traumatic Injuries Delta	63	4	30	10	11	3	2	8		131		
Trespassing/Unwanted Alpha				1						1		
Trespassing/Unwanted Bravo			1							1		
Unconscious/Fainting Alpha	113	6	60	33	8	7	2	5	3	237		
Unconscious/Fainting Charlie	224	6	134	49	17	15	10	10	3	468		
Unconscious/Fainting Delta	567	22	306	125	46	29	12	24	13	1,144		
Unconscious/Fainting Echo	5		6	3					1	15		
Unknown	7		5					1		13		
Unknown Problem Bravo	441	43	245	131	37	36	9	26	25	993		
Unknown Problem Delta	53	2	31	9	2	3	3	1	1	105		
Vegetation/Wildland/Brush/Grass Fire Alpha				1						1		
Vegetation/Wildland/Brush/Grass Fire Bravo				1						1		
Vegetation/Wildland/Brush/Grass Fire Charlie	1			2						3		
Vegetation/Wildland/Brush/Grass Fire Delta				3						3		
Vehicle Fire Alpha	8									8		
Vehicle Fire Bravo	9		2							11		
Vehicle Fire Charlie	2			1						3		
Vehicle Fire Delta	1									1		
Vehicle Fire Delta Threat Struct				1						1		
Warrant Service	8		3							11		
Water/Ice/Mud Rescue Alpha			1							3		
Water/Ice/Mud Rescue Bravo			2	3						5		
Water/Ice/Mud Rescue Delta			3	6				1	1	11		



Call Type	Clearfield County Call Type Counts per EMS Agency											Total Call Count by Type
	Amery/Doran EMS	Brady Twp EMS	Clearfield EMS	Curwensville EMS	Houtzdale EMS	Raymer EMS	Irving EMS	Karlhus EMS	Nadara EMS	Mahaffey EMS		
Watercraft in Distress Delta				1								1
Weapons/Firearms Alpha	1		1									2
Weapons/Firearms Bravo	1											1
Weapons/Firearms Delta			1									1
Total Call Counts:	15,521	895	14,167	6,020		1,591	1,150	444	999	438		41,225



Clearfield County QRS – 36 Month Data (2023-2025)											
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Did not crew Rate in ESZ
Clearfield Borough QRS	17QRS2 – 371	17QRS2 – 60:56:26	376	0:05:52	0:02:04	0:07:59	0:04:27	0:09:31	0:15:48	133	35.37%
	17QRS2-2 – 4	17QRS2-2 – 5:41:39									
	17STA2 – 1	17STA2 – 0:00:00									
Coalport QRS	17QRS28 – 1,675	17QRS28 – 544:10:21	1,702	0:06:37	0:06:31	0:13:11	n/a	n/a	0:31:22	102	5.99%
	17QRS28-2 – 1	17QRS28-2 – 0:46:13									
	17QRS28-3 – 1	17QRS28-3 – 0:23:12									
Glen Richey QRS	17STA28 – 25	17STA28 – 0:01:36	516	0:07:15	0:08:09	0:15:23	n/a	n/a	0:25:53	49	9.50%
	17QRS7 – 515	17QRS7 – 128:43:16									
	17STA7 – 1	17STA7 – 0:18:27									
Lawrence Township Fire Dept QRS	17QRS5 – 498	17QRS5 – 64:28:33	499	0:06:36	0:05:10	0:11:14	n/a	n/a	0:16:42	262	52.51%
	17STA5 – 1	17STA5 – 0:21:03									
	17QRS39 – 137	17QRS39 – 38:34:26									
Northpoint QRS	17QRS45 – 409	17QRS45 – 171:25:50	415	0:11:12	0:06:59	0:18:07	n/a	n/a	0:35:28	15	3.61%
	17STA45 – 6	17STA45 – 0:00:00									
	17QRS18 – 698	17QRS18 – 196:16:08									
Winburne QRS	17STA18 – 9	17STA18 – 1:44:05	707	0:05:45	0:05:11	0:10:41	n/a	n/a	0:34:20	655	92.64%



Clearfield County QRS – 36 Month Data (2023-2025)											
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Did not crew Rate in ESZ
Averages/Totals for County:		1,213:51:15	4,352	0:07:20	0:05:39	0:12:52	n/a	n/a	0:26:10	1,254	28.81%
										931	



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Abdominal Pain Alpha	1	25	3	1		2	12		44
Abdominal Pain Charlie	1	26	7			1	9		44
Abdominal Pain Delta	2	3	3			1	3		12
Alarms Co Without Pt		1			1		1		3
Allergies Envenomations Stings Bites Alpha		2	1			1			4
Allergies Envenomations Stings Bites Bravo		1							1
Allergies Envenomations Stings Bites Charlie		6				1	3		10
Allergies Envenomations Stings Bites Delta	3	5		1	1	2	5		17
Animal Bites Attacks Alpha		1	1						2
Animal Bites Attacks Bravo			1						1
Animal Bites Attacks Delta		1							1
Assault / Sexual Assault Bravo						1			1
Assault / Sexual Assault Ems Alpha		3							3
Assault / Sexual Assault Ems Bravo		1	1						2
Assault / Sexual Assault Ems Delta	1								1
Assault / Sexual Assault Charlie	1								1
Assist Other Agencies Bravo	1				1				2
Assist Other Agencies Delta	1								1
Back Pain Alpha		17	8			2	8		35
Back Pain Charlie		8	2				2		12
Back Pain Delta			2						2



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Backcountry Rescue Delta				1				1	
Breathing Problems Charlie		44	5	2		8	7	66	
Breathing Problems Delta	76	132	47	7	6	28	34	330	
Breathing Problems Echo	1	3		3				7	
Burns Explosion Alpha Fire Alarm	1							1	
Burns Scalds Explosion Blast Alpha			1					1	
Burns Scalds Explosion Blast Charlie		1						1	
Burns Scalds Explosion Blast Delta		1						1	
Carbon Monoxide/Inhale/Hazmat/Cbrn Delta					1			1	
Cardiac/Respiratory Arrest/Death Bravo		10	2	1	1	2	3	19	
Cardiac/Respiratory Arrest/Death Delta	3	5		7	5	2	2	24	
Cardiac/Respiratory Arrest/Death Echo	11	38	10	47	15	7	3	131	
Cardiac/Respiratory Arrest/Death Echo 3 Hanging	1	4			2			7	
Cardiac/Respiratory Arrest/Death Echo 4 Strangulation		1					1	2	



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Cardiac/Respiratory Arrest/Death Omega Expected Death		1						1	
Chest Pain Alpha		7	1					8	
Chest Pain Charlie	1	26	4	1		8	17	57	
Chest Pain Charlie Cocaine		1						1	
Chest Pain Delta	33	102	24	110	22	20	34	345	
Choking Delta	4	3		6	3	1	2	19	
Choking Echo				1				1	
Confined Space/Structure Collapse Bravo						1		1	
Convulsions/Seizures Alpha		8	4	1	1	3	1	18	
Convulsions/Seizures Bravo		4	4		1			9	
Convulsions/Seizures Charlie		8	5			1	8	22	
Convulsions/Seizures Delta	17	20	6	3		8	15	69	
Deceased Person Bravo		1						1	
Diabetic Problems Alpha		14				1	1	16	
Diabetic Problems Charlie		25	4	1		4	3	37	
Diabetic Problems Delta	5	2	1			1		9	
Energ Medasst	4	4	2	3		2	5	20	
Ems Standby		8	2			1	3	14	
Explosion Bravo			1					1	
Extrication/Entrapped Machinery, Veh Bravo	1	1				1	1	4	
Eye Problems/Injuries		1						1	
Falls Alpha	6	100	69	8	1	28	38	250	
Falls Bravo	5	93	27	8		18	28	179	
Falls Charlie		2	1					3	



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Falls Delta	31	23	12	7	1	9	14	97	
Fire Alarms Bravo		2						2	
Fire Alarms Charlie		6				1		7	
Fire Police		1		1			1	3	
Fuel Spill Bravo							1	1	
Gas Leak/Gas Odor Bravo					1			1	
Gas Leak/Gas Odor Charlie					1			1	
Headache Alpha		2					1	3	
Headache Charlie	1	8	1			2	1	13	
Heart Problems/Aicd Alpha			1				2	3	
Heart Problems/Aicd Charlie		28	6			5	8	47	
Heart Problems/Aicd Delta	9	18	9	27	9	1	7	80	
Heat/Cold Exposure Charlie		1						1	
Heat/Cold Exposure Delta		1						1	
Hemorrhage/Laceration Alpha		9	1	1			2	13	
Hemorrhage/Laceration Bravo	1	26	8	1		3	5	44	
Hemorrhage/Laceration Charlie			2					2	
Hemorrhage/Laceration Delta	15	36	7	52	10	7	12	139	
High Angle Rescue Bravo						1		1	
High Angle Rescue Delta			1					1	
Landing Zone			2		1	2	4	9	
Medical Assist Fire	5	40	13	22	3	25	33	141	
Mutual Aid Delta		1						1	
Mvaals	1	1		2			6	10	
Nonemerg Medasst	3	5		3		5	5	21	



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Overdose/Poisoning Bravo (Ingestion)		2	1			1		4	
Overdose/Poisoning Charlie (Ingestion)	2	15	1			2	8	28	
Overdose/Poisoning Delta (Ingestion)	7	8	2	4	2	1		24	
Overdose/Poisoning Echo (Ingestion)		2		1				3	
Overdose/Poisoning Omega (Ingestion)			1				1	2	
Pregnancy/Childbirth/Miscarriage Bravo		2				1		3	
Pregnancy/Childbirth/Miscarriage Delta	2	2		3	3	2		12	
Psychiatric/Abnormal Behavior/Suicide Attempt Alpha		32	5			9	6	52	
Psychiatric/Abnormal Behavior/Suicide Attempt Bravo		12	4			7	9	32	
Psychiatric/Abnormal Behavior/Suicide Attempt Charlie		1		1				2	
Psychiatric/Abnormal Behavior/Suicide Attempt Delta	10	4	2	1		3	7	27	
Public Service Alpha		1		1				2	
Search Detail						1	1	2	
Service Call Alpha		3	1	1		3	1	9	



Clearfield County Call Type Counts per QRS Agency										
Call Type	QRS Agency Counts							Total Call County by Type		
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne			
Sick Person Alpha	1	152	40	7		43	60	303		
Sick Person Bravo		23	2	1		4	5	35		
Sick Person Charlie	3	79	37	2	2	16	48	187		
Sick Person Delta	26	36	8	2	4	15	19	110		
Stab/Gunshot/Penetrating Trauma Bravo		2						2		
Stab/Gunshot/Penetrating Trauma Delta		2	2	2	2		1	9		
Stroke (Cva)/Transient Ischemic Attack (Tia)	3	48	10	2	2	6	18	89		
Stroke (Tia)/Transient Ischemic Attack (Tia)		1						1		
Struct Fire Chimney		1						1		
Struct Fire Com / Indust		1					1	2		
Struct Fire Echo 3 Com/Indust		1						1		
Struct Fire Electrical Problem		1						1		
Struct Fire Lg Non-Dwell		2				1	2	5		
Struct Fire Mobile Home		1				1	4	6		
Struct Fire Multi Res							1	1		
Struct Fire Single Res		9	2			4	4	19		
Struct Fire Sm Non-Dwell							1	1		
Struct Fire Smoke Odor							1	1		
Struct Fire Unknown							1	1		
Structure Fire							1	1		
Test Call	2							2		
Traffic Collision/Trans Incident Alpha	1	9	1			2	4	17		



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Traffic Collision/Trans Incident Bravo	5	19	4			6	20	54	
Traffic Collision/Trans Incident Charlie	3	17	4		1	4	15	44	
Traffic Collision/Trans Incident Delta	8	47	17		1	14	38	125	
Traffic Collision/Trans Incident Delta High Mechanism		1					2	3	
Traffic Collision/Trans Incident Delta Multi Vehicle		1					1	2	
Traffic Control		1					1	2	
Traffic Violation/Complaint/Hazard Bravo		1						1	
Traffic/Transportation Accident Alpha	1	2						3	
Traffic/Transportation Accident Bravo		1	1					2	
Traffic/Transportation Accident Delta							1	1	
Traffic/Transportation Incident Alpha			1			1	4	6	
Traffic/Transportation Incident Bravo		3						3	
Traffic/Transportation Incident Delta	1	3				1	2	7	
Transfer/Interfacility Alpha				1				1	
Traumatic Injuries Alpha		14	3	1	1	6	6	31	



Clearfield County Call Type Counts per QRS Agency									
Call Type	QRS Agency Counts							Total Call County by Type	
	Clearfield	Coalport	Glen Richey	Lawrence	Northpoint	Westover	Winburne		
Traumatic Injuries Bravo		7	1	1		4	6	19	
Traumatic Injuries Delta	4	8	2	5	3	1	3	26	
Unconscious/Fainting Alpha		12	3			2	6	23	
Unconscious/Fainting Charlie	2	26	8	3		3	5	47	
Unconscious/Fainting Delta	42	56	20	128	27	17	24	314	
Unconscious/Fainting Echo	1		1	2				4	
Unknown Problem Bravo		46	18	2	1	16	16	99	
Unknown Problem Delta	4	5	2		1		2	14	
Vehicle Fire Bravo		1						1	
Water/Ice/Mud Rescue Delta	1							1	
Watercraft In Distress Alpha		1						1	
Weapons/Firearms Delta	1							1	
Total Call Counts:	376	1702	516	499	137	414	707	4351	



Clearfield County's EMS system handled 41,225 incidents between 2023 and 2025, providing a substantial dataset for evaluating operational performance. Overall, the county's EMS agencies demonstrated performance that is generally consistent with rural EMS systems throughout Pennsylvania. Countywide averages included a dispatch-to-enroute time of 8 minutes and 34 seconds, an enroute-to-arrival time of just over seven minutes, a total dispatch-to-arrival response time of fifteen minutes, a transport time of nearly twenty-seven minutes, a hospital turnaround time of forty-six minutes, and a total call commitment time of 1 hour, 22 minutes.

The most significant contributor to the overall response interval appears to be the dispatch-to-enroute component. While urban and suburban EMS systems often strive for turnout times of less than two minutes, rural EMS systems frequently experience longer delays because personnel respond from home, work, or other locations prior to staffing an ambulance. Several of Clearfield County's larger and more consistently staffed agencies demonstrated considerably lower turnout times, including Clearfield EMS at four and a half minutes and Amserv/Dusan EMS at just under five minutes. In contrast, agencies such as Karthaus EMS, Mahaffey EMS, Brady Township EMS, and Irvona EMS experienced turnout times exceeding ten minutes, with Karthaus averaging more than fourteen minutes. These findings suggest that staffing models, rather than geography, may be the primary factor affecting response performance in portions of the county.

Travel times from enroute to arrival were relatively consistent among agencies. This suggests that station locations are generally positioned appropriately relative to their service areas and population centers. Compared to national rural EMS benchmarks, travel times are favorable and indicate that once crews begin responding, they are able to reach patients within reasonable timeframes despite the geographic challenges associated with a rural county. Consequently, improvements in overall response performance are likely to be achieved more effectively through staffing initiatives and turnout time reductions rather than station relocations.

The countywide dispatch-to-arrival time of just over fifteen falls within the range commonly reported by rural EMS systems nationally. However, considerable variation exists among agencies. Clearfield EMS, Curwensville EMS, and Amserv/Dusan EMS averaged response times between approximately eleven minutes, while Karthaus EMS exceeded twenty-one minutes and several other agencies approached or exceeded seventeen minutes. These longer response intervals are particularly important when evaluating care for time-sensitive emergencies, where early intervention is associated with improved outcomes.

Transport times provide additional insight into the challenges faced by rural EMS agencies. The countywide average transport interval was nearly twenty-seven minutes, with several agencies



averaging transport times exceeding thirty-five minutes. Karthaus EMS averaged more than 43 minutes per transport, while Houtzdale-Ramey, Irvona, Madera, and Mahaffey all averaged around thirty-five minutes. These transport times reflect both geographic realities and limited access to healthcare facilities within portions of the county. As healthcare services continue to consolidate regionally and rural hospitals face ongoing challenges, transport times may increase further, placing additional strain on EMS resources and reducing ambulance availability within the studied region.

The most noteworthy finding within the dataset is the amount of time EMS crews spend at receiving facilities. The countywide average hospital turnaround time was forty-six minutes, substantially higher than many national benchmarks. Many EMS systems target patient handoff times of less than twenty minutes and total hospital turnaround times of less than thirty minutes. While agencies such as Clearfield EMS and Brady Township EMS reported hospital times of approximately twenty-four minutes, other agencies experienced significantly longer delays. Irvona EMS averaged over an hour and a half at the hospital, while Mahaffey EMS averaged more than one hour and Houtzdale-Ramey EMS averaged more than fifty-one minutes. These delays result in ambulances remaining unavailable for extended periods, particularly for agencies already challenged by limited staffing and long transport distances.

As is the case with almost all other county EMS agencies within the studied region, reducing hospital turnaround times may represent the single greatest opportunity to improve system performance without adding new ambulances or personnel. EMS systems throughout Pennsylvania and nationally have improved turnaround times through several strategies, including dedicated EMS triage nurses, rapid patient offload protocols, streamlined registration processes, and designated EMS handoff areas within emergency departments. Regular monitoring and reporting of facility-specific turnaround times can also help identify trends and encourage collaborative improvement efforts between hospitals and EMS providers.

The data also reveal important workforce and system-reliability concerns. Countywide, EMS agencies reported a 4.0% "did not crew" rate, meaning calls within their assigned service areas could not be staffed. Several agencies reported substantially higher rates, including Brady Township EMS (40%), Karthaus EMS (38.1%), Mahaffey EMS (34.7%), and Irvona EMS (16.4%). These figures are indicative of the volunteer and workforce challenges affecting EMS agencies throughout Pennsylvania. High rates of unavailable units increase reliance on mutual aid, lengthen response times, and place additional demands on neighboring agencies.

The call-type data reveal patterns that align with national EMS utilization trends. Falls, sick person calls, breathing problems, chest pain, stroke-related incidents, psychiatric emergencies,



and interfacility transports account for a significant portion of EMS activity. Of particular note is the large volume of fall-related responses, behavioral health incidents, and interfacility transfers. These are categories where emerging EMS models such as community paramedicine, mobile integrated healthcare programs, fall prevention initiatives, behavioral health response teams, and alternative destination programs have shown success in reducing EMS utilization and emergency department demand.

Overall, the data indicates that Clearfield County's EMS system performs comparably to many other rural EMS systems with respect to travel and transport intervals, but opportunities for improvement exist in turnout times, hospital turnaround times, and resource availability. Continued efforts to strengthen staffing models, improve coordination with hospitals, expand use of QRS resources, and explore regional EMS collaboration will likely provide the greatest benefit. Among all performance measures, reducing hospital turnaround times appears to offer the most immediate and measurable opportunity to increase ambulance availability and improve overall system efficiency without requiring substantial capital investment.



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Appendix F3 – Elk County Data Displays



Elk County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
Bennett's Valley EMS	17A4151 – 714	17A4151 – 905:54:19	1,334	0:08:43	0:08:53	0:17:20	0:27:53	0:52:12	1:30:34	195	40	14.62%
	17A4152 – 493	17A4152 – 690:58:00										
	17STA41 – 127	17STA41 – 0:00:00										
Fox Township EMS	24A321 – 984	24A321 – 895:51:38	1,442	0:08:44	0:04:41	0:13:16	0:19:54	0:34:49	1:05:42	75	181	5.20%
	24A322 – 245	24A322 – 71:53:59										
	24A323 – 51	24A323 – 141:19:19										
	24STA320 – 162	24STA320 – 0:09:09										
Ridgway EMS	24A421 – 1,294	24A421 – 771:34:07	3,718	0:06:38	0:05:45	0:11:47	0:18:00	0:19:04	0:46:05	48	95	1.29%
	24A422 – 1,132	24A422 – 720:41:14										
	24A423 – 1,058	24A423 – 814:45:26										
	24MEDIC3 – 182	24MEDIC3 – 226:12:55										
	24STA420 – 52	24STA420 – 0:00:00										

Elk County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
St. Mary's EMS	24A121 – 1,972	24A121 – 771:48:55	9,922	0:05:18	0:07:25	0:12:20	0:10:40	0:24:11	0:47:20	615	317	6.20%
	24A122 – 2,984	24A122 – 1,890:55:54										
	24A123 – 2,052	24A123 – 1,477:57:43										
	24A124 – 1,174	24A124 – 780:51:10										
	24A125 – 332	24A125 – 223:52:33										
	24MEDIC12 – 1,385	24MEDIC12 – 1,380:30:07										
	24STA120 – 22	24STA120 – 7:07:01										
Wilcox EMS	24R611 – 509	24R611 – 325:06:26	509	0:11:08	0:05:37	0:16:14	0:18:57	0:15:30	0:54:38	113	38	22.20%
Averages/Totals for County:		7,348:06:11	16,925	0:08:06	0:06:28	0:14:11	0:19:05	0:29:09	1:00:52	1,046	671	6.18%



Elk County Call Type per EMS Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
>New Call<		4		2		6
24 Notes				2		2
24 Other	5	3	5	7	5	25
24 Paper Service				1		1
42 Ems Interfacility			1			1
911 Hangup			2	7		9
Abdominal Pain Alpha	21	13	49	74	5	162
Abdominal Pain Charlie	24	13	45	98	4	184
Abdominal Pain Delta	4	2	7	8	4	25
Abuse/Abandonment/Neglect Bravo				1		1
Administrative Alpha				1		1
Administrative Bravo				1		1
Alarms Co Without Pt	1		1	1		3
Allergies Envenimations Stings Bites Alpha	2	3	7	10		22
Allergies Envenimations Stings Bites Bravo	1		1	1		3
Allergies Envenimations Stings Bites Charlie	4		17	27	3	51
Allergies Envenimations Stings Bites Delta	5	5	7	30	1	48
Animal Bites Attacks Alpha				4		4
Animal Bites Attacks Bravo		1	3	4	1	9
Animal Bites Attacks Delta		1		1		2
ASAP To PSAP Fire Bravo		2		11	2	15
ASAP To PSAP Fire Charlie		3		47	5	55
ASAP To PSAP Medical Bravo	3	30	15	196		244
Assault / Sexual Assault Delta				7		7
Assault / Sexual Assault Ems Alpha	3	1	2	2		8
Assault / Sexual Assault Ems Bravo	3		6	10		19
Assault / Sexual Assault Ems Delta				2		2
Assault/Sexual Assault Charlie			1	3		4



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Assault/Sexual Assault Charlie 1 Shooting Just Occurred			2	1		3
Assault/Sexual Assault Delta 2 Stabbing			1			1
Assist Other Agencies Bravo			1			1
Back Pain Alpha	13	11	32	72	8	136
Back Pain Charlie	9	5	7	37	2	60
Back Pain Delta		2		6		8
Backcountry Rescue Bravo	1			1		2
Bomb Threat Charlie Pd Bomb			1			1
Break In Bravo			1			1
Breathing Problems Charlie	23	18	96	206	10	353
Breathing Problems Delta	79	67	227	696	24	1,093
Breathing Problems Echo		5	10	23	1	39
Burns Scalds Explosion Blast Charlie			1			1
Burns Scalds Explosion Blast Delta			1		1	2
Burns Scalds Explosion Blast Echo		1		1		2
Carbon Monoxide/Inhalation/Hazmat/CBRN Charlie			1	1		2
Carbon Monoxide/Inhale/Hazmat/ CBRN Bravo			1	1	1	3
Carbon Monoxide/Inhale/Hazmat/ CBRN Delta	1		2	3		6
Cardiac/Respiratory Arrest/Death Bravo	7	4	13	31	4	59
Cardiac/Respiratory Arrest/Death Delta	3	2	9	17	3	34
Cardiac/Respiratory Arrest/Death Echo	14	13	38	92	5	162
Cardiac/Respiratory Arrest/Death Echo 3 Hanging		1	1	1		3
Cardiac/Respiratory Arrest/Death Omega Expected Death	1		1	1		3
Chest Pain Alpha	1	2	5	11		19
Chest Pain Charlie	25	11	52	152	6	246
Chest Pain Charlie Cocaine			1			1
Chest Pain Delta	97	25	131	340	16	609
Choking Alpha	1	1	4	4		10



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Choking Delta	6	1	7	11		25
Choking Echo		1		6		7
Confined Space/Structure Collapse Bravo				1		1
Confined Space/Structure Collapse Delta				1		1
Convulsions/Seizures Alpha	3	3	20	33	4	63
Convulsions/Seizures Bravo	2	3	7	19	2	33
Convulsions/Seizures Charlie	11	7	35	58		111
Convulsions/Seizures Delta	12	8	40	90	5	155
Damage/Vandalism/Mischief Bravo				1		1
Diabetic Problems Alpha		3	21	43	2	69
Diabetic Problems Charlie	6	7	39	97	2	151
Diabetic Problems Delta	2		3	15		20
Disturbance Alpha			1			1
Disturbance Bravo				1		1
Disturbance Charlie			1	1		2
Disturbance Delta			1	3		4
Domestic Bravo	1	1		2	1	5
Domestic Charlie	1			3		4
Domestic Delta		1	7	7		15
Drowning (Near)/Diving/Scuba Accident Alpha		1		1		2
Drowning (Near)/Diving/Scuba Accident Delta			1			1
Drugs Charlie				1		1
Drugs Delta			1	1		2
Electrical Hazard Alpha				1		1
Electrical Hazard Bravo					11	11
Electrical Hazard Charlie					4	4
Electrical Hazard Delta	1			2		3
Electrocution/Lightning Delta		1		2		3



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Elevator/Escalator Rescue Bravo				3		3
Extrication/Entrapped Machinery, Veh Delta			1	1		2
Extrication/Entrapped Machinery,Veh Bravo		1	1	2		4
Eye Problems/Injuries	3		3	5		11
Falls Alpha	94	94	231	588	42	1,049
Falls Bravo	84	79	222	532	25	942
Falls Charlie	3	3	3	9		18
Falls Delta	26	17	58	151	11	263
Fire Alarms Bravo		6	1	17	2	26
Fire Alarms Charlie	1	15	1	64	4	85
Fire Police	1					1
Follow up Investigation				3		3
Gas Leak/Gas Odor Bravo	1		1		3	5
Gas Leak/Gas Odor Charlie	1		2	1	3	7
Gas Leak/Gas Odor Delta				1		1
Headache Alpha	2	1	6	11	1	21
Headache Charlie	1	4	11	30	1	47
Heart Problems Charlie Cocaine			1		1	2
Heart Problems/Aicd Alpha	2		2	3	1	8
Heart Problems/Aicd Charlie	6	5	27	50	3	91
Heart Problems/Aicd Delta	15	7	28	55	4	109
Heat/Cold Exposure Alpha	2		1	2		5
Heat/Cold Exposure Bravo			1	2		3
Heat/Cold Exposure Charlie			1	1		2
Heat/Cold Exposure Delta	1			3		4
Hemorrhage/Laceration Alpha	4	1	20	26	2	53
Hemorrhage/Laceration Bravo	19	17	39	80	6	161
Hemorrhage/Laceration Charlie	3		3	4		10



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Hemorrhage/Laceration Delta	17	13	42	102	4	178
Inaccessible Incident				2		2
Inaccessible Incident Bravo Peripheral Entrapment			1			1
Landing Zone				2		2
Launch EMD Proqa		2	1	6	1	10
Lost Person Charlie		2	3			5
Medical Assist Fire	20					20
Mental Disorder (Behavior Problems) Bravo	3	3	7	5	1	19
Mental Disorder (Behavior Problems) Charlie			3	4		7
Mental Disorder (Behavior Problems) Delta			4	3		7
Missing/Runaway/Found Person Bravo	1		2			3
Missing/Runaway/Found Person Charlie			2	1		3
Missing/Runaway/Found Person Delta	1	2	1	2		6
Mutual Aid Bravo	1					1
Mvaals	1					1
Nonemerg Medasst				1		1
Odor Unknown Charlie			1	2		3
Outside Fire Alpha	1	1				2
Outside Fire Bravo	4			1	1	6
Outside Fire Echo				1		1
Outside Fire Endangering Structure		1				1
Outside Tank Fire Delta					1	1
Overdose/Poisoning Bravo (Ingestion)	2	2	3	11		18
Overdose/Poisoning Charlie (Ingestion)	5	7	20	59	1	92
Overdose/Poisoning Delta (Ingestion)		1	9	20	4	34
Overdose/Poisoning Echo (Ingestion)	1		2	6		9
Overdose/Poisoning Omega (Ingestion)	1	1	3	3		8
Phone Call	33	150	45	16		244



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Pregnancy/Childbirth/Miscarriage Alpha	1		2	2		5
Pregnancy/Childbirth/Miscarriage Bravo			3			3
Pregnancy/Childbirth/Miscarriage Charlie			4	5		9
Pregnancy/Childbirth/Miscarriage Delta	3		14	16	1	34
Psychiatric/Abnormal Behavior/Suicide Attempt Alpha	5		8	16	2	31
Psychiatric/Abnormal Behavior/Suicide Attempt Bravo	7	5	12	22	2	48
Psychiatric/Abnormal Behavior/Suicide Attempt Charlie	1	3	8	26	1	39
Psychiatric/Abnormal Behavior/Suicide Attempt Delta	2	1	6	13	1	23
Psychiatric/Abnormal Behavior/Suicide Attempt Omega				4		4
Public Service Alpha	15	30	37	68	5	155
Public Service Bravo		2	1	9		12
Public Service Charlie				2		2
Public Service Delta			1	6		7
Pursuit				1		1
Search Detail		1				1
Service Call Alpha	1			2		3
Service Call Alpha Lift Assist	1			6		7
Sick Person Alpha	103	95	369	695	45	1,307
Sick Person Bravo	8	3	8	21	1	41
Sick Person Charlie	71	43	145	433	17	709
Sick Person Delta	22	23	64	151	9	269
Stab/Gunshot/Penetrating Trauma Bravo		3		1		4
Stab/Gunshot/Penetrating Trauma Delta	2		3	3		8
Stroke (CVA)/Transient Ischemic Attack (TIA)	24	38	119	282	14	477
Stroke (TIA)/Transient Ischemic Attack (TIA)			1	1	1	3
Struct Fire Appliance Contained				1		1
Struct Fire Chimney	1					1
Struct Fire Com / Indust		1	1	13		15



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Struct Fire Echo 13 Unknown	1					1
Struct Fire Echo 3 Com/Indust		1		1	2	4
Struct Fire Echo 4 Com / Hazmat					1	1
Struct Fire Echo 5 Multi Resid				4		4
Struct Fire Echo 6 Single Res	2	4	4	8	4	22
Struct Fire Echo 7 Lrg Non-Dwell				1		1
Struct Fire Echo 8 Sm Non-Dwell	1	1		3		5
Struct Fire Echo 9 Mobile Home	1	1				2
Struct Fire Echo Entrapment				2		2
Struct Fire Entrapment	2			5		7
Struct Fire High Rise				3		3
Struct Fire Lg Non-Dwell		1		1		2
Struct Fire Mobile Home	1	1				2
Struct Fire Multi Res				4	1	5
Struct Fire Single Res	12	12	3	20	2	49
Struct Fire Sm Non-Dwell				2		2
Struct Fire Unknown				1		1
Structure Fire	3					3
Structure Fire Delta 11 Mix Use Occupancy		1		1		2
Suicidal Person/Attempt Suicide	1	3	6	5	3	18
Suspicious/Wanted Bravo				1		1
Suspicious/Wanted Charlie			3	4		7
Test, Test, Test		1	2	3		6
Theft/Larceny Delta				1		1
Traffic Collision/Trans Incident Alpha	3	1				4
Traffic Collision/Trans Incident Bravo	6			3	2	11
Traffic Collision/Trans Incident Charlie	6	1				7
Traffic Collision/Trans Incident Delta	16	1		1		18



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Traffic Collision/Trans Incident Delta High Mechanism		1	1	1		3
Traffic Collision/Trans Incident Echo			1			1
Traffic Control			1			1
Traffic Stop			2		1	3
Traffic Violation/Complaint/Hazard Bravo			3		1	4
Traffic Violation/Complaint/Hazard Charlie				2		2
Traffic Violation/Complaint/Hazard Delta			1			1
Traffic/Transportation Accident Alpha	2	1	1	3		7
Traffic/Transportation Accident Bravo	7	8	12	24	2	53
Traffic/Transportation Accident Charlie	3	2	5	8	2	20
Traffic/Transportation Accident Delta		2	1	4		7
Traffic/Transportation Incident Alpha	3	8	13	23	3	50
Traffic/Transportation Incident Alpha Not Dangerous Area			2		2	4
Traffic/Transportation Incident Bravo	14	21	33	53	9	130
Traffic/Transportation Incident Bravo Unknown	15	20	46	64	13	158
Traffic/Transportation Incident Delta	9	11	16	28	5	69
Traffic/Transportation Incident Delta High Mechanism	11	10	28	54	6	109
Traffic/Transportation Incident Delta Major Incident	1		3	4	2	10
Traffic/Transportation Incident Delta Pedestrian Struck			1	4		5
Traffic/Transportation Incident Delta Pinned	2	4	12	14	3	35
Transfer/Interfacility Alpha	1		1	315		317
Transfer/Interfacility Charlie		1	1	287		289
Transfer/Interfacility Charlie 1			2	192	1	195
Transfer/Interfacility Delta		1		5		6
Transport	43	193	534	1,340		2,110
Traumatic Injuries Alpha	6	4	25	55		90
Traumatic Injuries Bravo	5	5	31	37	6	84
Traumatic Injuries Delta	4	1	10	20	1	36



Elk County Call Type Per Ems Agency						
Call Type	EMS Agency Counts					
	Bennett's Valley EMS	Fox Township EMS	Ridgway EMS	St. Mary's EMS	Wilcox EMS	Total Call Type:
Trespassing/Unwanted Charlie		1	4	1		6
Trespassing/Unwanted Delta			1			1
Unconscious/Fainting Alpha	15	15	37	107	7	181
Unconscious/Fainting Charlie	21	30	79	190	15	335
Unconscious/Fainting Delta	37	39	78	248	18	420
Unconscious/Fainting Echo	1	2	2	7		12
Unknown				3		3
Unknown Problem Bravo	52	62	79	375	13	581
Unknown Problem Delta	3	2	20	33	3	61
Veg/Wild/Brsh/Grs Fire Structure Threatened	1				2	3
Vegetation/Wildland/Brush/Grass Fire Bravo			1		2	3
Vegetation/Wildland/Brush/Grass Fire Charlie					8	8
Vegetation/Wildland/Brush/Grass Fire Delta					3	3
Vehicle Fire Bravo				1	3	4
Water/Ice/Mud Recue Delta Swift Water - 72			1	1		2
Water/Ice/Mud Rescue Delta			1			1
Total Call Counts:	1,334	1,442	3,718	9,922	509	16,925

The 36-month analysis of Elk County EMS data (2023–2025) shows that overall system performance aligns well with typical rural EMS benchmarks, though there are clear opportunities for operational improvement, particularly in hospital turnaround times and turnout consistency. Countywide, the average dispatch-to-enroute time is eight minutes and six seconds, enroute-to-arrival time is six minutes and twenty-eight seconds, and total dispatch-to-arrival time is fourteen minutes and eleven seconds. Transport time averages just over nineteen minutes, while time spent at the hospital averages just over twenty-nine minutes, contributing to a total call time of approximately one hour.

Response times across the county are generally consistent with rural national standards but vary significantly by agency. Turnout time, which reflects dispatch-to-enroute performance, ranges from a low of 5:18 at St. Mary's EMS to a high of 11:08 at Wilcox EMS. This variation is reflective of the differences in staffing models, with faster agencies likely benefiting from more consistent or scheduled staffing. Travel time (enroute-to-arrival) is strong across the system, averaging 6:28 and remaining well within expected rural norms. Agencies such as Fox Township and Ridgway demonstrate especially efficient travel times, likely due to geographic coverage.

Total response time (dispatch to arrival) averages 14:11, which is appropriate for a rural system where national expectations typically range from twelve to twenty minutes. Ridgway and St. Marys EMS perform at the high end of efficiency, with response times near twelve minutes, while Bennett's Valley and Wilcox trend higher, exceeding sixteen minutes. These differences highlight the impact of both turnout delays and geographic coverage gaps. From a system design



perspective, this suggests that response reliability could be improved through better unit distribution, cross-agency coverage, or dynamic deployment strategies.

After accounting for response, transport, and hospital intervals, estimated on-scene time falls in the range of approximately eighteen to twenty minutes. This aligns closely with national EMS practice, where medical calls typically require fifteen to twenty minutes on scene.

Transport times average nineteen minutes and are largely driven by geography and hospital availability. These times fall within expected rural ranges, generally between fifteen and thirty minutes. There is variation among agencies, with St. Marys reporting the shortest average transport time at approximately ten minutes and Bennett's Valley the longest at nearly twenty-eight minutes.

The most significant opportunity for improvement lies in hospital turnaround time. The county average of twenty-nine minutes is at the upper limit of what is generally considered acceptable, and several agencies exceed this threshold. Bennett's Valley, in particular, has an average hospital time of over fifty-two minutes, which represents a substantial inefficiency and reduces system availability. In contrast, Ridgway and Wilcox demonstrate much more efficient turnaround times, closer to fifteen to twenty minutes, showing that improved performance is achievable within the same regional healthcare environment. Prolonged hospital times are a well-documented national issue and are often related to emergency department crowding and offload delays.

To address this, a coordinated effort among agencies and health networks should prioritize strategies aimed at reducing time spent at hospitals. These may include developing formal offload agreements with local hospitals to establish expected transfer times, implementing dedicated EMS triage or offload areas, improving pre-arrival communication to expedite patient registration, and standardizing handoff procedures to allow for faster transfer of care. Additionally, expanding the use of alternative destination protocols or treat-and-release options for low-acuity patients could reduce unnecessary emergency department utilization and, in turn, improve turnaround times.

Another notable issue is the variability in "did not crew" rates, with a county average of 6.18% but significantly higher rates in certain agencies, particularly Wilcox (22.2%) and Bennett's Valley (14.6%).

Call type data further supports national trends, with the highest volumes associated with breathing problems, falls, sick persons, chest pain, and unconscious patients. These are common EMS call categories nationwide and often include a high proportion of low- to moderate-acuity



patients. This presents an opportunity for system-level innovation, such as community paramedicine programs, fall prevention initiatives, and care coordination with primary care providers to reduce repeat EMS utilization. Implementing these types of programs has been shown nationally to decrease call volume and improve system efficiency over time.

In summary, Elk County EMS agencies are performing well in core operational areas such as response and transport times, with metrics that are consistent with rural national standards. The primary opportunities for improvement are concentrated in hospital turnaround times, turnout time variability, and coverage reliability. By focusing on hospital offload efficiency, strengthening staffing models, enhancing system coordination, and exploring alternative care pathways, Elk County can significantly improve overall system performance while maintaining high-quality patient care.



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Appendix F4 – Jefferson County Data Displays



Jefferson County Call Type Counts per Agency										
Call Type	Agency Counts							Total Call Type Counts		
	Brockway EMS	JCEMS 50	JCEMS 90	Dubois EMS	Dusan EMS	Reynoldsville EMS	Sykesville EMS			
>New Call<	25	56	86		1	1		169		
911 Hang Up / Accidental Dial	1	2	3	2	1			9		
Abdominal Pain - ALS	19	31	26	4	22	12	8	122		
Abdominal Pain - BLS	57	142	90	7	52	30	33	411		
Alarm - Fire	10	90	70	1	8	23	11	213		
Alarm - Medical	152	803	407	11	161	148	75	1757		
Alarm - Police	2	6						8		
Allergies/Envenomations - ALS	6	14	8	2	6	3	5	44		
Allergies/Envenomations - BLS	11	27	17	2	10	7	1	75		
Animal Bites/Attacks - ALS	1	1			1	1		4		
Animal Bites/Attacks - BLS	2	11	5			2		20		
Animal Complaint/Investigation					1	1		2		
Assault		10	3		1	2	1	17		
Assault/Sexual Assault - ALS		1						1		
Assault/Sexual Assault - BLS	1	13	5	1	5	6	2	33		
Assist	2	4	1				1	8		
ATV / UTV Accident	2	7	4	1	6	6	2	28		
Back Pain - ALS	3	9	6		7	3	1	29		
Back Pain - BLS	52	69	46	4	32	20	14	237		
Breathing Problems - ALS	224	644	463	39	307	149	154	1980		
Brush/Outside Fire	12	8	28	1	1	20	5	75		
Building Collapse		1						1		
Burglary					1		1	2		
Burns - ALS		1	1					2		
Burns - BLS	2	5	2				1	10		
Carbon Monoxide Alarm Only	1	2			1			4		
Carbon Monoxide Incident	7	7	7	1	1	3	1	27		
Cardiac/Resp Arrest - ALS	16	67	52	4	30	21	10	200		
Cardiac/Resp Arrest - BLS	21	58	48	4	25	23	13	192		



Jefferson County Call Type Counts per Agency										
Call Type	Agency Counts									
	Brockway EMS	JCEMS 50	JCEMS 90	Dubois EMS	Dusan EMS	Reynoldsville EMS	Sykesville EMS	Total Call Type Counts		
Chest Pain – ALS	84	203	134	16	128	70	44	679		
Chest Pain - BLS	51	132	93	6	82	37	28	429		
Children and Youth			1					1		
Choking - ALS	3	8	8	1	5	3	3	31		
Choking - BLS	4	15	8	1	5	3	2	38		
Cold Exposure - ALS			1					1		
Cold Exposure - BLS	2	2						4		
Confined Space Rescue	1	2	1			1		5		
Controlled Burn		4					1	5		
Convulsions/Seizures - ALS	14	89	64	4	53	43	19	286		
Convulsions/Seizures - BLS	33	119	99	6	85	65	25	432		
Customer/Civil Dispute			2					2		
Diabetic Problem - ALS	16	34	31	5	20	7	9	122		
Diabetic Problem - BLS	28	65	53	6	22	13	11	198		
Disabled Vehicle	1		1					2		
Disorderly Subject		4	2					6		
Domestic Dispute	5	17	9		7	8	4	50		
Electrocution/Lightning - ALS			1					1		
Entrapment/Inaccessible - ALS		2			1	1		4		
Entrapment/Inaccessible - BLS	2	6						8		
Explosion					1		2	3		
Eye Problem/Injuries - BLS	1	4	4		1		1	11		
Falls - ALS	45	186	131	9	73	36	42	522		
Falls - BLS	312	1205	903	37	387	277	202	3323		
Fight	1	4				1		6		
Follow Up Investigation	1	3	1					5		
Gun Shots		1	1					2		
Hazardous Condition			1					1		
HazMat Incident		1			1	1		3		



Jefferson County Call Type Counts per Agency									
Call Type	Agency Counts							Total Call Type Counts	
	Brockway EMS	JCEMS 50	JCEMS 90	Dubois EMS	Dusan EMS	Reynoldsville EMS	Sykesville EMS		
Headache - ALS	1	4	7	1	2	2	1	18	
Headache - BLS	8	18	9	2	9	6	5	57	
Heart Problems/AICD - ALS	31	101	65	3	41	24	15	280	
Heart Problems/AICD - BLS	33	126	100	6	40	25	15	345	
Heat Exposure - ALS	1	4	3	1	1	1		11	
Heat Exposure - BLS	2	4		1	2	1	1	11	
Hemorrhage/Lacerations - ALS	24	59	53	7	30	25	18	216	
Hemorrhage/Lacerations - BLS	44	124	109	6	52	42	17	394	
High Angle Rescue		5	1					6	
Hit and Run	2	1	1					4	
Intoxicated Person	3	6	1				1	11	
Landing Zone		1	3					4	
Lost/Found Property						1		1	
Misc Fire	1	2	1		1			5	
Misc Police	1	3	4				1	9	
Miscellaneous	3	17	11			1		32	
Missing/Runaway		2	6				1	9	
Mutual Aid		11	1					12	
MVA	103	233	428	14	149	99	52	1078	
MVA - ALS/Entrap	35	77	95	8	73	36	19	343	
MVA Police Only	2	5	7	2	2	1	1	20	
MVA-ALS Injuries		3	4		2	3	1	13	
Natural Gas in Structure/Confine	2	5	2		1	2		12	
Natural Gas Incident Outside			3					3	
Odor Investigation			1					1	
Overdose - ALS	3	21	15		13	5	3	60	
Overdose - BLS	8	28	32	1	19	12	4	104	
Phone Call Request	1		2				1	4	
Poisoning - ALS		2	1					3	



Jefferson County Call Type Counts per Agency								
Call Type	Agency Counts							Total Call Type Counts
	Brockway EMS	JCEMS 50	JCEMS 90	Dubois EMS	Dusan EMS	Reynoldsville EMS	Sykesville EMS	
Poisoning - BLS		1	3		1		1	6
Pregnancy/OBGYN - ALS		4	5	1	2	4	1	17
Pregnancy/OBGYN - BLS	6	16	3	1	4	1	3	34
Probation						1		1
Psychiatric/Suicidal - ALS	12	20	13	3	9	3	7	67
Psychiatric/Suicidal - BLS	80	328	225	7	117	88	125	970
Public Works		1						1
Reckless Driver	1	3						4
Request to See Officer			3					3
Road Closure	1	1	1					3
Robbery - Armed/Strong Armed	1							1
Routine Transport	767	745	1488		1		2	3003
Sick Person - ALS	88	256	192	19	125	66	64	810
Sick Person - BLS	376	1125	919	45	449	263	299	3476
Smoke Investigation					1			1
Special Detail		1						1
Stab/Gunshot - ALS	2	7	5		2	1		17
Stab/Gunshot - BLS	1	3	4					8
Stand-By Assignment	96	1150	996	2	5	8	1	2258
Stroke - ALS	32	100	75	9	50	19	20	305
Stroke - BLS	20	81	81	7	43	17	18	267
Structure Fire	45	130	85	1	32	29	44	366
Structure Fire HH	5		1			1		7
Subject w/Weapon		1						1
Suspicious Person/Vehic/Activity	2	4	10		1		1	18
Theft			1					1
Threats/Harassment	1	1	1		2	1		6
Traffic Control/Clean up		3						3
Traumatic Injuries - ALS	7	21	20	1	13	7	5	74



Jefferson County Call Type Counts per Agency								
Call Type	Agency Counts							Total Call Type Counts
	Brockway EMS	JCEMS 50	JCEMS 90	Dubois EMS	Dusan EMS	Reynoldsville EMS	Sykesville EMS	
Traumatic Injuries - BLS	20	64	40	4	35	23	17	203
Tree Down			2		1			3
Trespass	1							1
TS		1	6					7
Unconscious/Fainting - ALS	61	162	130	5	73	37	25	493
Unconscious/Fainting - BLS	68	166	116	9	91	50	35	535
Unknown Problem - ALS	2	20	9	1	6	7	1	46
Unknown Problem - BLS	19	63	47	2	22	17	17	187
Unwanted Person		4	4					8
Vehicle Fire	7	28	51	4	19	6	7	122
Warrant Service		2	1					3
Welfare Concern	6	15	19		3	4	1	48
Total Call Counts:	3,268	9,584	8,448	348	3,095	1,986	1,582	28,311

Data Limitation:

The data display for Jefferson County differs from the other data displays produced due to the functional differences on the CAD system for data extraction and the availability and/or format of reports. The above data reflects the information able to be extracted and compiled as provided to MCM as of the writing of this report. All other data received was determined unusable or not in a format conducive with the information extrapolated in other data sets. For example, information such as did not crew rates, dispatch to enroute times, dispatch to arrival times, dispatch to on scene, etc.



The Jefferson County EMS data provided differs significantly from the other dataset in that it does not include detailed time interval metrics such as dispatch-to-enroute, response (enroute-to-arrival), on-scene time, transport time, or hospital turnaround time. As noted in the document, limitations in the CAD system and reporting format prevented extraction of key performance indicators such as response times, turnout times, and hospital intervals. As a result, a direct quantitative analysis of response, on-scene, transport, and hospital times, along with precise comparisons to state and national benchmarks, is not possible with the available Jefferson County dataset. However, important conclusions can still be drawn by examining call volume distribution, call types, and system utilization patterns, and by applying established EMS standards and best practices in Pennsylvania and nationally.

Jefferson County agencies responded to a total of 28,311 calls across the reporting period, with the largest call volumes attributed to JCEMS 50 (9,584 calls) and JCEMS 90 (8,448 calls), followed by Brockway EMS (3,268) and Dusan EMS (3,095). This distribution indicates a system where a small number of agencies respond to the majority of the calls for service. From a system performance standpoint, high call concentration often correlates with improved response efficiency due to better staffing and deployment density, whereas lower-volume agencies may experience longer turnout times and reduced availability due to reliance on volunteer staffing or limited coverage hours. Even without explicit timing data, this structural characteristic suggests that response times in higher-volume areas likely align more closely with national targets, while rural or lower-volume areas may experience longer delays.

The distribution of call types in Jefferson County closely mirrors local trends. The most frequent call categories include sick person (3,476 BLS and 810 ALS), routine transports (3,003), falls (3,323 BLS and 522 ALS), breathing problems (1,980 ALS), alarm-medical calls (1,757), and psychiatric or behavioral emergencies (970 BLS). These categories are consistent with national data showing that EMS systems are heavily utilized for low- to moderate-acuity medical conditions, chronic illness exacerbations, and non-emergent transport needs. This pattern has important implications for response and operational efficiency. While high-acuity calls such as cardiac arrest, trauma, and stroke require rapid response and short on-scene times, a large proportion of EMS workload involves patients who could potentially be managed through alternative care pathways, telehealth, or community-based programs. In systems with this call mix, total call time, including on-scene and hospital time, often increases due to clinical evaluation, patient decision-making, and emergency department delays.

Although specific time metrics are not available, national and Pennsylvania EMS standards provide a framework for evaluating likely system performance. In rural and semi-rural environments similar to Jefferson County, typical benchmarks include turnout times of 5–10



minutes for volunteer or combination systems, response times of 12–20 minutes for priority calls, on-scene times of 15–20 minutes for medical incidents, transport times of 15–30 minutes depending on hospital access, and hospital turnaround times of 20–30 minutes under normal conditions. Based on the call volume distribution and the presence of multiple transport-capable agencies, it is reasonable to infer that Jefferson County’s transport times likely fall within expected rural ranges, while response and turnout times may vary by agency depending on staffing models and station coverage.

Hospital time, often referred to as EMS-to-wall time, is not directly reported in this dataset but remains one of the most critical factors affecting EMS system performance nationwide. Given the high volume of routine transports and lower-acuity medical calls in Jefferson County, there is a strong likelihood that emergency department throughput and patient offload delays play a significant role in overall unit availability. In areas with similar call profiles, prolonged hospital times are commonly driven by emergency department crowding, delays in triage or bed assignment, and limited capacity for rapid EMS offload. Reducing hospital turnaround time is therefore a key opportunity for improving system efficiency. Strategies supported by Pennsylvania and national EMS best practices include establishing formal offload time expectations with hospitals, implementing EMS triage or offload areas for low-acuity patients, improving pre-arrival notifications to hospitals, and streamlining transfer-of-care processes so EMS crews can return to service more quickly.

Additional opportunities for system improvement in Jefferson County include optimizing deployment and addressing system demand through alternative service models. Given the concentration of call volume among a few agencies, dynamic deployment strategies, such as posting units based on peak demand times and locations, could improve response consistency. Expanding the use of tiered response models, where basic life support units handle lower-acuity calls while advanced life support units are reserved for critical incidents, could also improve resource utilization. Furthermore, the high frequency of calls related to falls, sick persons, and behavioral health indicates a strong opportunity for community paramedicine or mobile integrated healthcare programs. These programs, which are increasingly supported in Pennsylvania, aim to reduce repeat EMS utilization by providing proactive care, follow-up visits, and coordination with primary care providers and social services.

From a system design perspective, the large number of routine transports and standby assignments shows that EMS resources may be significantly tied up in non-emergency activities. Evaluating the appropriateness of these assignments and exploring alternative transport options, such as non-emergency medical transportation services, could help reduce system strain. Additionally, enhancing mutual aid coordination and ensuring closest-unit response policies are



consistently applied can improve coverage and reduce gaps in service, particularly in lower-volume areas.

In conclusion, while the Jefferson County dataset lacks the time-based metrics necessary for a direct analysis, the available data provides valuable insight into system demand and operational characteristics. The county's call profile closely aligns with national EMS trends, with a high proportion of low-acuity and chronic-condition calls that drive overall system utilization. Based on national and Pennsylvania standards, Jefferson County's performance likely falls within expected rural ranges, though variability in staffing and coverage may affect response consistency. The most impactful opportunities for improvement include reducing hospital turnaround times, optimizing deployment strategies, expanding alternative care programs, and better aligning resources with call demand. By addressing these areas, Jefferson County can enhance system efficiency, improve response reliability, and maintain high-quality patient care despite the limitations of the available data.



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Appendix F5 – McKean County Data Displays



McKean County EMS – 36 Month Data (2023-2025)

Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
Bradford City EMS	42AMB01 – 1	42AMB01 – 0:00:00	7,277	0:03:43	0:04:57	0:08:15	0:08:34	0:21:16	0:41:57	225	30	3.09%
	42M1A - 13	42M1A – 5:28:41										
	42MA1 – 4,285	42MA1 – 2,685:18:37										
	42MA1A – 2,656	42MA1A – 2,144:14:09										
	42MA1B - 224	42MA1B – 197:35:05										
	42MEDIC1 - 98	42MEDIC1 – 96:56:19										
Emergency Care EMS	42AMB05 - 2	42AMB05 – 0:00:00	3,239	0:05:27	0:10:38	0:15:48	0:10:39	0:27:14	1:01:38	162	68	5.00%
	42M5 - 27	42M5 – 12:59:04										
	42MA5 – 3,152	42MA5 – 3,015:00:57										
	42MA5A - 58	42MA5A – 31:09:34										
Mt. Jewett EMS	42AMB10 – 1	42AMB10 – 0:00:00	792	0:10:01	0:07:42	0:17:25	0:20:03	0:44:37	1:15:08	215	136	27.15%
	42MA10 – 733	42MA10 – 514:07:25										



McKean County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
	42MA10A - 58	42MA10A – 38:07:45										
Phoenix EMS	421701 – 3	421701 – 0:00:00	732	0:06:04	0:10:23	0:16:26	0:31:40	1:13:11	1:44:45	3	153	0.41%
	42AMB17 – 8	42AMB17 – 0:00:00										
	42MA17 – 367	42MA17 – 368:12:53										
	42MA17A – 354	42MA17A – 564:06:17										
Port Allegany EMS	42301 – 4	42301 – 0:20:18	3,153	0:07:03	0:09:30	0:16:25	0:33:29	0:53:44	1:30:02	189	212	5.99%
	42AMB03 – 3	42AMB03 – 0:00:00										
	42M3 – 27	42M3 – 12:41:31										
	42MA3 – 2,454	42MA3 – 3,348:40:45										
	42MA3A – 665	42MA3A – 792:09:54										



McKean County EMS – 36 Month Data (2023-2025)												
Agencies	Calls Dispatched per Unit	Total Committed Time per Unit (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate in ESZ
TLC EMS	42123 – 1,130	42123 – 1,719:56:20	1,387	0:08:39	0:11:49	0:19:52	0:26:54	1:16:41	1:51:02	64	214	4.61%
	422401 – 7	422401 – 0:00:00										
	422402 – 2	422402 – 0:10:10										
	422403 – 0	422403 – 7:52:17										
	42AMB24 – 5	42AMB24 – 0:18:48										
	42M24 – 6	42M24 – 14:19:34										
	42MA24A – 212	42MA24A – 335:04:26										
	42MA24B – 25	42MA24B – 37:28:34										
TransAM EMS	NYOL10 - 142	NYOL10 – 105:53:29	142	0:14:01	0:12:14	0:25:56	0:24:14	0:48:32	1:05:30	42	0	29.58%
Averages/Totals for County:		16,048:12:52	16,722	0:07:51	0:09:36	0:17:10	0:22:13	0:49:19	1:18:35	900	813	5.38%



Call Type	EMS Agency Counts							
	Bradford City EMS	EmergencyCare EMS	Mt. Jewett EMS	Phoenix EMS	Port Allegany EMS	TLC EMS	TransAM EMS	Total Call Type: 14
>New Call<	3	2	1	3	3	2		2
42 911 Hang Up					2			2
42 Ems Detail	2/	8	2	8	16	38		99
42 Ems Interfacility	156	128	6	/9	/3	98		540
42 Equipment Failure		2	1	1		1		5
42 Fire Detail	3							3
42 Follow Up	2							2
42 Police Detail						1		1
42 Transport Coordinator			14	13	8	54		89
42 Weather Alert		3	3		2	2		10
62 BSA Transfer		1						1
Abdominal Pain Alpha	105	32	10	13	70	19	1	250
Abdominal Pain Charlie	79	29	4	9	47	24	5	197
Abdominal Pain Delta	14	4	2		11	3	2	36
Administrative Alpha	3				2			5
Administrative Bravo						2		2
Aircraft Bravo Unknown		1						1
Aircraft Delta	1							1
Alarms Bravo		1						1
Alarms Charlie		1				1		2
Alarms Co Without Pt	4	1	1	3	2	1		12
Allergies Envenomations Stings Bites Alpha	16	2	1	1	5	2		27
Allergies Envenomations Stings Bites Bravo	1							1
Allergies Envenomations Stings Bites Charlie	20	4	2	3	12	6	3	50
Allergies Envenomations Stings Bites Delta	31	5	1	1	11	9	1	59
Animal Bites Attacks Alpha	3	1			2	1		7
Animal Bites Attacks Bravo	5		1	1		5		12
Animal Bites Attacks Delta	1				1			2
Animal Bravo	1							1
Animal Delta	1							1
Assault / Sexual Assault Bravo	4	1				1		6
Assault / Sexual Assault Delta	14	1			4			19
Assault / Sexual Assault Ems Alpha	3				1			4
Assault / Sexual Assault Ems Bravo	18	8	1		4	2		33
Assault / Sexual Assault Ems Delta	8	6	1		1			16
Assault / Sexual Assault Charlie	5				2			7
Assault / Sexual Assault Charlie 1 Shooting Just Occurred	3	1	1					5
Assault / Sexual Assault Charlie 2 Stabbing Just Occurred		1	1					2
Assault / Sexual Assault Delta Shooting	1	1						2
Assist Other Agencies Bravo	12	1		2	2			17
Back Pain Alpha	61	35	8	8	34	19	1	166
Back Pain Charlie	20	9	3	1	11	5	1	50
Back Pain Delta	3	3	1		3	1		11



McKean County Call Type Counts per EMS Agency								
Call Type	EMS Agency Counts							
	Bradford City EMS	EmergencyCare EMS	Mt. Jewett EMS	Phoenix EMS	Port Allegany EMS	TLC EMS	TransAM EMS	Total Call Types:
Backcountry Rescue Delta		2			1			3
Backcountry Rescue Bravo		3						3
Backcountry Rescue Charlie	1							1
Bomb/Suspicious Package Delta Hi Occupancy Package	1							1
Break In Charlie		1						1
Break In Delta		1						1
Breathing Problems Charlie	142	53	19	11	73	31	5	334
Breathing Problems Delta	525	235	63	42	285	89	23	1262
Breathing Problems Echo	4	4	1		2			11
Burns Explosion Charlie 1 Person Qa Fire	1							1
Burns Scalds Explosion Blast Alpha	3	2			3			8
Burns Scalds Explosion Blast Charlie	5				1	2		8
Burns Scalds Explosion Blast Delta	1							1
Carbon Monoxide/Inhalation/Hazmat/Cbrn Charlie		1						1
Carbon Monoxide/Inhalation/Hazmat/Cbrn Omega		1						1
Carbon Monoxide/Inhale/Hazmat/Cbrn Bravo	4							4
Carbon Monoxide/Inhale/Hazmat/Cbrn Delta	2					1		3
Cardiac/Respiratory Arrest/Death Bravo	42	22	9	2	10	6	1	92
Cardiac/Respiratory Arrest/Death Delta	21	13	4	4	7			49
Cardiac/Respiratory Arrest/Death Echo	103	54	9	10	46	15	2	239
Cardiac/Respiratory Arrest/Death Echo 3 Hanging	4				1			5
Cardiac/Respiratory Arrest/Death Omega Expected Death	4	1	1	1	2	2		11
Chest Pain Alpha	25	5	1		2	5		38
Chest Pain Charlie	113	46	10	6	50	13	1	239
Chest Pain Charlie Cocaine	3				2			5
Chest Pain Delta	277	108	32	35	135	52	16	655
Choking Alpha	7	2	1	1	3	1		15
Choking Delta	9	5	3	1	2			20
Choking Echo	1	1						2
Convulsions/Seizures Alpha	76	17	2	1	14	9		119
Convulsions/Seizures Bravo	27	7	2	1	10	2	1	50
Convulsions/Seizures Charlie	66	20	1	3	26	13	3	132
Convulsions/Seizures Delta	115	37	6	4	47	9	3	221
Diabetic Problems Alpha	29	16	4	2	16	5		72
Diabetic Problems Charlie	80	30	6	5	43	18	4	186
Diabetic Problems Delta	15	2		1	9			27
Disturbance Bravo	3					1		4
Disturbance Charlie	5				1			6
Disturbance Delta	14	1						15
Domestic Bravo	2	1	2		1	1		7
Domestic Charlie	3				2			5
Domestic Delta	14	6	1		2	3		26
Drugs Delta	1				1			2
Dui Delta					1			1
Electrical Hazard Bravo	1							1



McKean County Call Type Counts per EMS Agency									
Call Type	EMS Agency Counts								
	Bradford City EMS	EnergyCare EMS	Mt. Jewett EMS	Phoenix EMS	Port Allegany EMS	TLC EMS	TransAM EMS	Total Call Type:	
Electrical Hazard Delta					1			1	
Electrocution/Lightning Charlie					1			1	
Electrocution/Lightning Delta		1				1		2	
Elevator/Escalator Rescue Alpha	2							2	
Enns Standby	1					1		2	
Explosion Bravo	2							2	
Explosion Delta	1	1	1					3	
Extrication/Entrapped Machinery, Veh Delta	2							2	
Extrication/Entrapped Machinery, Veh Bravo	6	1	1					8	
Eye Problems/Injuries	7	2			1			10	
Falls Alpha	563	249	60	52	262	74	4	1264	
Falls Bravo	394	200	44	37	168	59	1	903	
Falls Charlie	7	10	1		13	3		34	
Falls Delta	154	73	14	19	58	27	3	348	
Fire Alarms Bravo	11	4	2	1	5	4		27	
Fire Alarms Charlie	8	2	5			4		19	
Followup Investigation	1	1						2	
Gas Leak/Gas Odor Bravo	2							2	
Gas Leak/Gas Odor Charlie	1	1	1		1			4	
Gas Leak/Gas Odor Delta	2			1	2	1		6	
Harassment/Stalking/Threat Alpha					1			1	
Harassment/Stalking/Threat Delta					1			1	
Hazmat Bravo	2							2	
Headache Alpha	9	4	1	1	4	4		23	
Headache Bravo	1					1		2	
Headache Charlie	14	15		1	6	1	1	38	
Heart Problems Charlie Cocaine					1			1	
Heart Problems/Acid Alpha	5	1			1	1		8	
Heart Problems/Acid Charlie	45	21	5	7	38	16	3	135	
Heart Problems/Acid Delta	52	21	6	11	42	12	5	149	
Heat/Cold Exposure Alpha	1				2	1		4	
Heat/Cold Exposure Bravo	5	1			1			7	
Heat/Cold Exposure Charlie		1						1	
Heat/Cold Exposure Delta	4	2		1	1	1		9	
Hemorrhage/Laceration Alpha	23	13	2	3	11	4		56	
Hemorrhage/Laceration Bravo	96	44	6	14	47	19		226	
Hemorrhage/Laceration Charlie	17	3	1		4	6	1	32	
Hemorrhage/Laceration Delta	75	45	11	5	33	12	1	182	
Inaccessible Incident		1						1	
Inaccessible Incident Bravo Peripheral Entrapment					1			1	
Landing Zone	122	1		1	1			125	
Launch Emd Proqa			1					1	
Launch Emd Proqa	3							3	
Launch Emd Proqa	1							1	
Lift Assist		3						3	
Lost Person Charlie		1						1	



McKean County Call Type Counts per EMS Agency								
Call Type	EMS Agency Counts							
	Bradford City EMS	EmergencyCare EMS	Mt. Jewett EMS	Phoenix EMS	Port Allegany EMS	TLC EMS	TransAM EMS	Total Call Types:
Lost Person W/ Injuries		1						1
Mental Disorder (Behavior Problems) Bravo	8	5	3		3	1		20
Mental Disorder (Behavior Problems) Charlie	1		1	1		2		5
Mental Disorder (Behavior Problems) Delta	2					1		3
Miscellaneous Bravo		1						1
Missing/Runaway/Found Person Bravo		2			1			3
Missing/Runaway/Found Person Charlie		1						1
Mutual Aid Delta	1				1			2
Odor Unknown Alpha	1							1
Odor Unknown Charlie	2	1		1				4
Outside Fire Alpha	2							2
Outside Fire Bravo	1					1		2
Outside Fire Delta	1							1
Outside Fire Endangering Structure						1		1
Overdose/Poisoning Bravo (Ingestion)	25	11	2	1	3	2		44
Overdose/Poisoning Charlie (Ingestion)	92	20	5	7	22	7	1	154
Overdose/Poisoning Delta (Ingestion)	38	11	2		5			56
Overdose/Poisoning Echo (Ingestion)	3	3			1			7
Overdose/Poisoning Omega (Ingestion)	9	3	1		3	1		17
Phone Call						1		1
Pregnancy/Childbirth/Miscarriage Alpha	1	1			1			3
Pregnancy/Childbirth/Miscarriage Bravo	20			1	4			25
Pregnancy/Childbirth/Miscarriage Charlie	16	2	2	1	4	1		26
Pregnancy/Childbirth/Miscarriage Delta	27	3			4	1		35
Psych		5						5
Psychiatric/Abnormal Behavior/Suicide Attempt Alpha	23	11	6	2	22	1		65
Psychiatric/Abnormal Behavior/Suicide Attempt Bravo	42	15	6	5	13	4		85
Psychiatric/Abnormal Behavior/Suicide Attempt Charlie	13	7	3		8	3		34
Psychiatric/Abnormal Behavior/Suicide Attempt Delta	22	11		1	4	2		40
Psychiatric/Abnormal Behavior/Suicide Attempt Omega	2				3			5
Public Service Alpha	7		2	3		2		14
Public Service Bravo	15	5	1	1	3	1		26
Public Service Charlie		1						1
Public Service Delta	1	1						2
Pursuit					1			1
Robbery Delta 2	1							1
Search Detail	2							2
Service Call Alpha	5	1			1	1		8
Service Call Alpha Lift Assist	8	3		2	13	3	1	30
Service Call Bravo								
Service Call Charlie	1	1						2
Sick Person Alpha								1
	697	310	67	59	295	121	3	1,552



McKean County Call Type Counts per EMS Agency										
Call Type	EMS Agency Counts									
	Bradford City EMS	EmergencyCare EMS	Mt. Jewett EMS	Phoenix EMS	Port Allegany EMS	TLC EMS	TransAM EMS	Total Call Type:		
Sick Person Bravo	36	12	2	2	10	5		67		
Sick Person Charlie	271	145	34	28	155	58	8	699		
Sick Person Delta	181	92	16	19	103	38	4	453		
Smoke Investigation Alpha	1							1		
Smoke Investigation Charlie	1							1		
Stab/Gunshot/Penetrating Trauma Bravo	1	2			1			4		
Stab/Gunshot/Penetrating Trauma Delta	7	1	1		3	2		13		
Stroke (Ova)/Transient Ischemic Attack (Tia)	167	86	22	14	79	27	6	401		
Stroke (Tia)/Transient Ischemic Attack (Tia)	1	1	1			1		4		
Struct Fire Appliance Contained	1							1		
Struct Fire Chimney					1			1		
Struct Fire Com / Indust		4	1		4			9		
Struct Fire Echo 13 Unknown					1			1		
Struct Fire Echo 3 Com/Indust	1	2	1		3	1		8		
Struct Fire Echo 4 Com / Hazmat			1					1		
Struct Fire Echo 5 Multi Resid	2	1		1	3			7		
Struct Fire Echo 6 Single Res	8	11	7	1	7	2		36		
Struct Fire Echo 7 Lrg Non-Dwell		1	1		1	1		4		
Struct Fire Echo 8 Sm Non-Dwell		2	1					3		
Struct Fire Echo 9 Mobile Home		1	1		1			2		
Struct Fire Echo Entrapment	1							2		
Struct Fire Electrical Problem		1	1		1	1		4		
Struct Fire Entrapment	2	2	1	1	3			9		
Struct Fire High Life		1						1		
Struct Fire High Rise		1						1		
Struct Fire Lg Non-Dwell					1			1		
Struct Fire Mobile Home					2	1		3		
Struct Fire Multi Res		1						1		
Struct Fire Single Res	8	10	4	1	9	7		39		
Struct Fire Sm Non-Dwell						1		1		
Struct Fire Unknown		1						1		
Structure Fire Echo 1 High Life Hazard		1			2			3		
Suicidal Person/Attempt Suicide	13	7			7	1		28		
Suspicious/Wanted Bravo	3				1			4		
Suspicious/Wanted Charlie	6	1						7		
Theft/Larceny Charlie	1				1			1		
Theft/Larceny Delta	1							1		
Traffic Collision/Trans Incident Alpha	4	1			3			8		
Traffic Collision/Trans Incident Bravo	19	8	3	1	8	3		42		
Traffic Collision/Trans Incident Charlie	5	1	1		3	2	1	13		
Traffic Collision/Trans Incident Delta	6	4			2	1	1	14		
Traffic Collision/Trans Incident Delta High Mechanism	3	2	1	1	1			8		
Traffic Control						1		1		
Traffic Stop	1							1		
Traffic Violation/Complaint/Hazard Alpha	1					1		2		



McKean County Call Type Counts per EMS Agency									
Call Type	EMS Agency Counts							Total Call Type:	
	Bradford City EMS	EmergencyCare EMS	Mt. Jewett EMS	Phoenix EMS	Port Allegany EMS	TLC EMS	TransAM EMS		
Traffic Violation/Complaint/Hazard Bravo	1							1	
Traffic Violation/Complaint/Hazard Charlie	1							1	
Traffic/Transportation Accident Alpha	1	1			1			3	
Traffic/Transportation Accident Bravo	17	2		1	6	3		29	
Traffic/Transportation Accident Charlie	5				1	1		7	
Traffic/Transportation Accident Delta	1	1	1					3	
Traffic/Transportation Incident Alpha	49	18	5	4	15	5		96	
Traffic/Transportation Incident Alpha Not Dangerous Area	1	2	1		1			5	
Traffic/Transportation Incident Bravo	63	29	13	1	17	14	3	140	
Traffic/Transportation Incident Bravo Unknown	93	49	19	9	27	21	2	220	
Traffic/Transportation Incident Delta	53	23	16	4	24	15	1	136	
Traffic/Transportation Incident Delta High Mechanism	72	36	17	13	29	27	5	199	
Traffic/Transportation Incident Delta Major Incident	7	1		1	1	1		11	
Traffic/Transportation Incident Delta Pedestrian Struck	2				1			3	
Traffic/Transportation Incident Delta Pinned	15	9	4	1	5	7	2	43	
Train And Rail Fire Delta						1		1	
Transfer/Interfacility Alpha	13	9		13	2	1		38	
Transfer/Interfacility Charlie	15	5		18	20			58	
Transfer/Interfacility Charlie 1	11	6	2	13	14		4	50	
Transfer/Interfacility Delta	1							1	
Transport	8	55		14	35	36		148	
Traumatic Injuries Alpha	57	20	5	5	15	5		107	
Traumatic Injuries Bravo	34	12	5	5	16	7		79	
Traumatic Injuries Delta	18	8			8			34	
Trespassing/Unwanted Charlie	4	2						6	
Unconscious/Fainting Alpha	81	22	7	3	20	10		143	
Unconscious/Fainting Charlie	111	51	11	3	34	13	2	225	
Unconscious/Fainting Delta	291	128	35	19	121	42	5	641	
Unconscious/Fainting Echo	4	2	1			1		8	
Unknown	4				1			5	
Unknown Problem Bravo	324	185	44	21	63	38		675	
Unknown Problem Delta	58	12	2		8	1	1	82	
Vehicle Fire Delta Occupants Trapped					1			1	
Vehicle Fire Delta Threat Struct	1							1	
Water/Ice/Mud Rescue Alpha	1							1	
Water/Ice/Mud Rescue Charlie	1				1			2	
Water/Ice/Mud Rescue Delta		1						1	
Weapons/Firearms Charlie	1				1			2	
Weapons/Firearms Delta						1		1	
Total Call Counts:	1,211	3,239	792	732	3,153	1,381	142	16,122	



McKean County QRS – 36 Month Data (2023-2025)											
Agencies	Total Committed Time per Agency (hr:min:sec)	Total Calls	Average Dispatch to Enroute Time	Average Enroute to Arrival Time	Average Dispatch to Arrival Time	Average Transport to Hospital Time	Average Out of Service/ Time at Hospital	Average Total Call Time	Total Did not Crew Calls in ESZ	Calls out of ESZ Not Crewed	Did not crew Rate
Bradford Township QRS	1,440:53:57	796	0:06:09	0:07:11	0:13:45	n/a	n/a	0:51:15	82	226	10.30%
Corydon Township Fire QRS	296:28:51	148	0:07:54	0:10:32	0:18:15	n/a	n/a	1:05:53	20	13	13.51%
Derrick City Fire QRS	698:23:52	427	0:07:37	0:04:47	0:13:01	n/a	n/a	0:41:05	39	39	9.13%
Eldred Township Fire QRS	620:36:45	562	0:11:19	0:05:47	0:15:32	n/a	n/a	1:07:35	297	41	52.85%
Hamlin Township Fire QRS	450:09:23	279	0:09:59	0:08:38	0:18:29	n/a	n/a	0:59:45	44	29	15.77%
Hilltop Fire QRS	278:59:20	224	0:07:36	0:04:55	0:12:30	n/a	n/a	0:49:14	66	11	29.46%
Lafayette Township Fire QRS	1,600:17:13	533	0:05:30	0:07:39	0:13:05	n/a	n/a	0:54:31	16	29	3.00%
Lewis Run Fire QRS	246:06:04	223	0:06:00	0:03:42	0:09:47	n/a	n/a	0:40:54	31	18	13.90%
Port Allegany Fire QRS	1,126:27:02	800	0:09:33	0:07:15	0:16:37	n/a	n/a	0:49:59	34	53	4.25%
Rew Fire QRS	710:08:27	404	0:07:58	0:06:34	0:14:56	n/a	n/a	0:58:46	87	62	21.53%
Averages/Totals for County:	3,300:52:42	4,396	0:07:58	0:06:42	0:14:36	n/a	n/a	0:53:54	716	521	16.29%

McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										
	Bradford Twp	Corydon Twp	Derrick City	Eldred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	Total Call type
>New Call<	2		3	2	1	1	2	2	2	1	16
42 Des Detail									6		6
42 Ems Detail									1		1
42 Ems Interfacility				1		1			2		4
42 Equipment Failure	1	1	1	1	1	1	1		1	1	9
42 Fire Detail	9	5	8	1	1	1	4	4	8	2	43
42 Weather Alert	2	2	2	2	2	2	3	2	2	2	21
Abdominal Pain Alpha				7	1	1	3	1	2	3	18
Abdominal Pain Charlie				6	1		2	2	1	1	13
Abdominal Pain Delta									1	1	2
Administrative Alpha	4		1	1			1	1	3		11
Administrative Bravo	2								1		3
Aircraft Alpha Standby							3				3
Aircraft Delta							1				1
Alarms Bravo	2		1								3
Alarms Co Without Pt	14		7	7	1	1	3	5	13	1	52
Allergies Envenomations Stings Bites Charlie		2			2	1		1	2		8
Allergies Envenomations Stings Bites Delta		2		3			1	1	1	1	9
Animal Alpha	1										1
Animal Bites Attacks Bravo				1						1	2
Assault / Sexual Assault Ems Alpha							1				1
Assault / Sexual Assault Ems Bravo				2			1				3
Assault / Sexual Assault Ems Delta										1	1



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Assist Other Agencies Bravo	1	1	1	1			1	1	1		7
Assist Other Agencies Charlie			1							1	2
Back Pain Alpha				4		1	3	1	2	4	15
Back Pain Charlie				2	1		1	1	2		7
Back Pain Delta				1					1		2
Backcountry Rescue Delta									1		1
Backcountry Rescue	1	1									2
Breathing Problems Charlie		2		10	8	3	4	4	1	3	35
Breathing Problems Delta	3	2		28	20	11	22	9	17	21	133
Breathing Problems Echo	1										1
Carbon Monoxide/Inhale/Hazmat/Cbrn Delta	1					1					2
Cardiac/Respiratory Arrest/Death Bravo	1	1	1	2				2	2	1	10
Cardiac/Respiratory Arrest/Death Delta	2		4	1			2		2		11
Cardiac/Respiratory Arrest/Death Echo	14	1	12	9	2	4	3	4	23	4	76
Cardiac/Respiratory Arrest/Death Echo 3 Hanging	1	1					1				3



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										
	Bradford Twp	Corydon Twp	Derrick City	Edired Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	Total Call type
Cardiac/Respiratory Arrest/Death Omega Expected Death				1							1
Chest Pain Alpha				2	1			1			4
Chest Pain Charlie		2		6		1	5	5			19
Chest Pain Delta	3	2	2	11	6	13	10	7	4	4	62
Choking Alpha			1	1		1					3
Choking Delta							1			1	2
Choking Echo			1								1
Confined Space/Structure Collapse Bravo			1								1
Control Burn	4								1		5
Convulsions/Seizures Alpha		2		2		1	3		1	1	10
Convulsions/Seizures Bravo				1						1	2
Convulsions/Seizures Charlie				8		1			2	2	13
Convulsions/Seizures Delta		1	1	3		2	2		4	2	15
Diabetic Problems Alpha				1			1		1		3
Diabetic Problems Charlie		2		6		3	4		3	3	21
Diabetic Problems Delta	1		2			1			1		5
Domestic Charlie								1			1
Domestic Delta				1							1



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Electrical Hazard Alpha	6		2	2	1	1	1	1	4	1	19
Electrical Hazard Bravo	37	5	15	16	9	4	8	6	36	17	153
Electrical Hazard Charlie	7	4	7	1	4		8		12		43
Electrical Hazard Delta					1						1
Electrocution/Lightning Delta				1							1
Explosion Bravo	1				1						2
Explosion Charlie							1				1
Explosion Delta					1		1				2
Extrication/Entrapped Machinery, Veh Delta	1										1
Extrication/Entrapped Machinery, Veh Bravo	1										1
Falls Alpha	1	6		22	5	17	22	11	35	25	144
Falls Bravo			1	18	8	7	9	9	11	17	80
Falls Charlie					1			1		1	3
Falls Delta	5		6	12	1	7	8	3	5	4	51
Fire Alarms Bravo	28	10	10	6	1		3	16	9	3	86
Fire Alarms Charlie	232	1	54	4	3	1	10	10	19	2	336
Followup Investigation	1		1								2
Fuel Spill Bravo	3				1						4
Fuel Spill Charlie					1		1				2
Fuel Spill Delta					1						1
Gas Leak/Gas Odor Bravo	3		15	6	1		1	2	22	2	52
Gas Leak/Gas Odor Charlie	9		2			2		1	10		24



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Gas Leak/Gas Odor Delta			5			1	1	2	5		14
Hazmat Bravo			1								1
Headache Alpha				1		2					3
Headache Bravo				1							1
Headache Charlie				1		1					2
Heart Problems/Aicd Alpha				1							1
Heart Problems/Aicd Charlie				3	1		2			5	11
Heart Problems/Aicd Delta	1		1	7	2		1		4	2	18
Heat/Cold Exposure Bravo						2	1				3
Heat/Cold Exposure Delta		1		1							2
Hemorrhage/Laceration Alpha				1							1
Hemorrhage/Laceration Bravo	1			4			2	2	1	4	14
Hemorrhage/Laceration Charlie				1			1				2
Hemorrhage/Laceration Delta				9	1	1	5		2	2	20
Inaccessible Incident									1		1
Landing Zone	1		9	18	8	2		1	22	7	68
Launch Efd Proqa							1				1
Lost Person Charlie	1	4					6				11



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Mental Disorder (Behavior Problems) Bravo						1	1		1		3
Mental Disorder (Behavior Problems) Charlie							1				1
Miscellaneous Bravo	1										1
Missing/Runaway/Found Person Bravo		1					1		3		5
Missing/Runaway/Found Person Delta					1						1
Mutual Aid Alpha	1		1								2
Mutual Aid Bravo			2						1		3
Mutual Aid Delta									1		1
Nonemerg Medasst						1	1			1	3
Odor Unknown Alpha	1										1
Odor Unknown Bravo									1		1
Outside Fire Alpha			2	1			1				4
Outside Fire Bravo	8		6	4	2	1	3	1	3	2	30
Outside Fire Delta	1						1		3	1	6
Outside Fire Endangering Structure	1		3	2	1						7
Outside Tank Fire Delta					1						1
Overdose/Poisoning Bravo (Ingestion)						1			1	1	3
Overdose/Poisoning Charlie (Ingestion)				1	2	4	1		1		9



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Overdose/Poisoning Delta (Ingestion)	1		1		1		1	1	2		7
Overdose/Poisoning Echo (Ingestion)							1				1
Phone Call							1				1
Pregnancy/Childbirth/Mis carriage Bravo									1	1	2
Pregnancy/Childbirth/Mis carriage Charlie						1		1		1	3
Pregnancy/Childbirth/Mis carriage Delta				1					1	1	3
Psychiatric/Abnormal Behavior/Suicide Attempt Alpha						1				1	2
Psychiatric/Abnormal Behavior/Suicide Attempt Bravo					2	3	3	2			10
Psychiatric/Abnormal Behavior/Suicide Attempt Charlie				1			1				2
Psychiatric/Abnormal Behavior/Suicide Attempt Delta						2			1		3
Public Service Alpha	4			2	1		2		3	2	14
Public Service Bravo	2								2	1	5
Robbery Delta 2										1	1
Search Detail	4	3	2				3			1	13
Security	1										1



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Service Call Alpha	67	18	15	25	28	10	68	9	49	30	319
Service Call Alpha Lift Assist	2		2	2	1		1		11	1	20
Service Call Bravo	7	4	3	3	5	2	11	4	10	2	51
Service Call Charlie	2				1			1			4
Sick Person Alpha		3	1	35	6	7	19	12	19	18	120
Sick Person Bravo				1			2	1			4
Sick Person Charlie		1	1	19	7	3	8	5	7	5	56
Sick Person Delta		2		14	3	6	3	4	4	8	44
Smoke Investigation Alpha									3		3
Smoke Investigation Charlie	1		1						1	1	4
Stab/Gunshot/Penetrating Trauma Delta				2					2		4
Stroke (Cva)/Transient Ischemic Attack (Tia)		2		11	4	4	9	2	4	10	46
Struct Fire Appliance Contained				1					1		2
Struct Fire Chimney									1		1
Struct Fire Com / Hazmat									1		1
Struct Fire Com / Indust	7		2	2	3	1	1	1	9		26
Struct Fire Echo 13 Unknown									2		2
Struct Fire Echo 2 High Rise	1										1
Struct Fire Echo 3 Com/Indust	7		5	2	3		1	1	6	1	26



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										
	Bradford Twp	Corydon Twp	Derrick City	Edred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	Total Call type
Struct Fire Echo 4 Com / Hazmat	1										1
Struct Fire Echo 5 Multi Resid	4		3						7		14
Struct Fire Echo 6 Single Res	16	6	11	2	7	3	4	7	28	5	89
Struct Fire Echo 7 Lrg Non-Dwell	4	2	2	2	4	2	1	2	3	1	23
Struct Fire Echo 8 Sm Non-Dwell	2					2	3	2	2	1	12
Struct Fire Echo 9 Mobile Home	1		1		2				2		6
Struct Fire Echo Entrapment	5		1			1				1	8
Struct Fire Electrical Problem	2		2	1	1			1	2		9
Struct Fire Entrapment	7	1	3	1	1			1	7	1	22
Struct Fire High Life	6		1		1				4		12
Struct Fire High Rise	3										3
Struct Fire Lg Non-Dwell	1								8		9
Struct Fire Mobile Home	1			1					2		4
Struct Fire Multi Res	4		1			1	1		1	1	9
Struct Fire Single Res	13		13	13	8	5	3	2	37	8	102
Struct Fire Sm Non-Dwell	1		1	2	1	1	1		3	2	12
Struct Fire Unknown									3		3
Structure Fire Echo 1 High Life Hazard	3		1						2		6
Suicidal Person/Attempt Suicide						1	1				2



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										
	Bradford Twp	Corydon Twp	Derrick City	Edired Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	Total Call type
Traffic Collision/Trans Incident Alpha	3		1						1	1	6
Traffic Collision/Trans Incident Bravo	9	1	3	1	1	1	2	1	6	3	28
Traffic Collision/Trans Incident Charlie	1			3	1		3		2	2	12
Traffic Collision/Trans Incident Delta	1			1	1	1	1		1		6
Traffic Collision/Trans Incident Delta High							1			2	3
Traffic Control	5	7	22	10	6	6	24	8	34	14	136
Traffic Stop		1									1
Traffic Violation/Complaint/Hazard Alpha	8	2	5	2	3	1	4	1	6	7	39
Traffic Violation/Complaint/Hazard Bravo	4		1	3	1	1	1	1	2	5	19
Traffic Violation/Complaint/Hazard Charlie	2		4		3					2	11
Traffic Violation/Complaint/Hazard Charlie 2 - Hazerdous Roads				2							2
Traffic/Transportation Accident Alpha	2		2	1			1		1		7
Traffic/Transportation Accident Bravo	12	2	9	10	1	1	9		6	6	56



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										Total Call type
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	
Traffic/Transportation Accident Charlie	3								1		4
Traffic/Transportation Accident Delta	1										1
Traffic/Transportation Incident Alpha	9	2	6	2	2	4	11	2	9	9	56
Traffic/Transportation Incident Alpha Not Dangerous Area									1		1
Traffic/Transportation Incident Bravo	14	3	13	8	5	1	8		7	9	68
Traffic/Transportation Incident Bravo Unknown	23	1	19	12	7	2	18	2	15	13	112
Traffic/Transportation Incident Delta	10	2	6	7	11	4	13		10	8	71
Traffic/Transportation Incident Delta High Mechanism	10	1	12	14	8	2	12	1	13	13	86
Traffic/Transportation Incident Delta Major Incident	3		2								5
Traffic/Transportation Incident Delta Pedestrian									1		1
Traffic/Transportation Incident Delta Pinned	6		4	3	1	1	2		4		21
Train And Rail Fire Delta				1							1
Transfer Assignment	7	3	5	3	3		4	3	9	2	39
Transport									2		2
Traumatic Injuries Alpha				1	1	1	3		2	2	10



McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	Total Call type
Traumatic Injuries Bravo			1				1	1	1	1	5
Traumatic Injuries Delta	1						2		3	1	7
Unconscious/Fainting Alpha				5	2	3	1	2	1	2	16
Unconscious/Fainting Charlie	1		1	4	1	1	2	1	2	4	17
Unconscious/Fainting Delta	35	4	32	17	10	7	10	5	42	7	169
Unconscious/Fainting Echo			1	1							2
Unknown Problem Bravo	2	5		12	4	16	45	8	3	16	111
Unknown Problem Delta	1	1	2	1	1		2		3	1	12
Veg/Wild/Brsh/Grs Fire Structure Threatened				1	1				2		4
Veg/Wild/Brsh/Grs Fire With Structure Threatened	1		1	3	1				1		7
Vegetation/Wildland/Brush/Grass Fire Alpha								1			1
Vegetation/Wildland/Brush/Grass Fire Bravo			1	3	1		1		3		9
Vegetation/Wildland/Brush/Grass Fire Charlie	7	2	3	5	1	2	3		13	2	38
Vegetation/Wildland/Brush/Grass Fire Delta	2	2	2		1		2	1	3		13
Vehicle Fire Bravo	6			1	1	1	1	1	3	4	18
Vehicle Fire Charlie	1								2		3
Vehicle Fire Delta	1			1	1				1		4
Vehicle Fire Delta Occupants Trapped						1	1		1		3

McKean County Call Type Counts per QRS Agency											
Call Type	QRS Agency Counts										
	Bradford Twp	Corydon Twp	Derrick City	Edlred Twp	Hamlin Twp	Hilltop	Lafayette	Lewis Run	Port Allegany	Rew	Total Call type
Vehicle Fire Delta Threat Struct	3	1				1	3	2	1	1	12
Water/Ice/Mud Rescue Alpha		1									1
Watercraft In Distress Bravo		1									1
Weather/Disaster Situation Alpha		1	2	1	1	1	1	1	2	1	11
Weather/Disaster Situation Omega		1	1	1	1	1		1	1	1	8
Total Call Counts:	796	148	427	562	279	224	533	223	800	404	4396



The 36-month EMS dataset for McKean County demonstrates system-wide performance that is generally consistent with rural EMS trends in Pennsylvania. Countywide, the average dispatch-to-enroute time is seven minutes fifty-one seconds, enroute-to-arrival (travel time) is nine minutes thirty-six seconds, and total response (dispatch-to-arrival) is seventeen minutes ten seconds. These times reflect a typically rural geography with long travel distances and limited unit availability. Compared to national benchmarks, where urban response times often target eight minutes or less for high-acuity calls, McKean County's longer response intervals are not atypical and generally align with rural expectations, where total response times of fifteen to twenty minutes are common due to staffing models, volunteer reliance, and coverage gaps.

On-scene and transport-related intervals show additional patterns. Although a discrete "on-scene time" is not explicitly listed, it can be inferred within the overall call duration. The county's average transport time of twenty-two minutes thirteen seconds is relatively high but consistent with geographic realities and hospital distribution in rural Pennsylvania. Some agencies, such as Phoenix EMS and Port Allegany EMS, have even longer transport times (over thirty minutes), further reinforcing access challenges. These extended transport intervals are typical in rural EMS systems and may be unavoidable without system-level changes such as expanded ALS intercepts, additional transport units, or alternative destination protocols. Further complicating the average times in McKean County is the recent closure of Bradford Regional Medical Center (BRMC) as previously noted in this report.

The most significant operational concern identified in the dataset is time at hospital (out-of-service time), which averages forty-nine minutes nineteen seconds across the county, with several agencies exceeding one hour. This is notably higher than commonly cited national targets, where EMS systems often attempt hospital turnaround times of twenty to thirty minutes. The extended hospital times suggest there may be systemic inefficiencies, likely related to emergency department crowding, delays in patient handoff, limited staffing, or documentation processes. These delays significantly impact unit availability, contributing to increased response times and a countywide "did not crew" rate of 5.38%, with certain agencies experiencing severe staffing or availability challenges.

Several similarities to national patterns emerge. First, higher call volumes (e.g., Bradford City EMS with 7,277 calls) correlate with shorter response intervals and lower unit downtime, suggesting efficiency. Prior to the closure of BRMC, Bradford City had the ability to transfer most patients in a relatively short period and near immediate availability to handle subsequent calls for service. Second, smaller or more rural agencies consistently exhibit longer response, transport, and hospital times, reflecting national disparities in rural EMS performance. Third, call types, dominated by low-acuity complaints such as falls, sick person calls, breathing problems,



and chest pain, mirror national EMS utilization trends and indicate a high proportion of non-critical workload that still consumes significant system resources.

Opportunities for improving efficiency, particularly reducing hospital time, should be a priority. Strategies may include implementing formalized patient handoff protocols with local hospitals to streamline transfer of care, adopting monitoring, and reporting to track and address delays, and pursuing regional agreements or policies allowing EMS crews to clear more rapidly after transferring care responsibility. The county could also explore mobile integrated healthcare / community paramedicine programs, particularly for frequent low-acuity callers such as lift assists and minor medical complaints, which are well represented in the dataset.

From a system design perspective, addressing staffing and coverage gaps is critical. Agencies with high “did not crew” rates may benefit from regionalization, shared staffing models, or cross-agency deployment strategies, aligning with broader Pennsylvania trends toward consolidation in rural EMS. Deployment optimization, such as dynamic posting or peak-time staffing adjustments, may also help reduce response times in higher-demand zones. Finally, continued integration of QRS (Quick Response Service) agencies, whose average response time of fourteen minutes thirty-six seconds is slightly faster than EMS transport units, can enhance early patient contact and improve outcomes, particularly for time-sensitive emergencies.

In summary, McKean County’s EMS system performs within expected ranges for a rural region, but it faces notable challenges in hospital turnaround times, unit availability, and variability between agencies. Addressing hospital delays, strengthening regional coordination, and implementing alternative care pathways represent the most impactful opportunities to improve efficiency and align more closely with evolving EMS standards both in Pennsylvania and nationally.



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Appendix F6 – Potter County Data Displays



Potter County Call Type Counts per Agency																			
Call Type	Agency Counts																		
	E01	E02	E04	E07	E08	E09	E10	E11	E15	E25	E26	E27	E37	E39	E44	E46	E47	E49	Total Call Type Counts
911 Hang Up Call																		2	2
ALS Medical	79	122	410	15	19	2	31		18	77	448		22	8	297	55	74	381	2058
ALS Transfer	23	1	2	1	1		1		2		4				1			1	37
Assault											2								2
Assault With Injury										2									2
Automatic Fire Alarm											2				1			2	5
BLS Medical	88	69	175	16	20	1	27		10	47	190	4	22	5	106	39	37	225	1081
BLS Transfer	295	57	22	12	10		7	1	12	7	41	16	26	3	8	14	8	118	657
Carbon Monoxide			2												3			7	12
Check Welfare		2									4				1			4	11
Covid BLS															1			2	3
Dead Body		1																	1
Domestic	1	2	6	1							1							1	12
Entrapment											2								2
Fire Chimney															1				1
Gas In Structure			1															3	4
Gas Outside Structure			2												2		1	2	7
Hazmat			3												2				5
Helicopter Assist	7																		7
Land Rescue	5	2					1		4		3				4	1		2	22



Potter County Call Type Counts per Agency																			
Call Type	Agency Counts																		
	E01	E02	E04	E07	E08	E09	E10	E11	E15	E25	E26	E27	E37	E39	E44	E46	E47	E49	Total Call Type Counts
Lifting Assistance			3															2	5
Mass Ac 4-7 Injuries																3		2	5
Medical	1	2	4	1	1		1		1	13	4		5	1	5	22		1	62
Mutual Aid				1									5	1		1			8
MVA With Injuries	2	17	52				3	1	10	6	14	1	4		41	15	7	33	206
MVA With No Injuries			5								2				2			1	10
Odor Investigation			1								2							1	4
Other	3	1													4				8
Pole / Elec Fire			1																1
ProQA EMS	2		4										1	2				3	12
ProQA Fire																	3	2	5
ProQA Law Enforcement	2	1	1																4
Psychiatric			2							1	1		2				2	1	13
Public Service / EMS	7	4	11				1				4		3		2		1	4	37
Search			2						1										3
Smoke Investigation											1							2	3
Stand By EMS	7	5	4				2						6			1			25
Stand By Fire					1								3						4
Structure Fire	2	5	2	1							7			1	8	1	2	8	37



Potter County Call Type Counts per Agency																			
Call Type	Agency Counts																		
	E01	E02	E04	E07	E08	E09	E10	E11	E15	E25	E26	E27	E37	E39	E44	E46	E47	E49	Total Call Type Counts
Threats														1					1
Tower Accessed									1										1
Traffic Complaint								1											1
Traffic Pursuit											1								1
Transfer Fire													2						2
Tree Down													2		2				4
Unknown Conditions	2										2							2	6
Vehicle Fire	1		3								5				3		3	4	19
Water Rescue															5	1			6
Wild Fire		3	9								3		2		9				26
Wires Down																			3
Total Call Counts:	527	294	727	48	52	3	74	3	59	153	743	21	105	22	511	155	137	819	4453

Data Limitation:

The data display for Potter County differs from the other data displays produced due to the functional differences on the CAD system for data extraction and the availability and/or format of reports. The above data reflects the information able to be extracted and compiled as provided to MCM as of the writing of this report. All other data received was determined unusable or not in a format conducive with the information extrapolated in other data sets. For example, information such as did not crew rates, dispatch to enroute times, dispatch to arrival times, dispatch to on scene, etc.



The Potter County EMS data provided offers useful insight into call volume, call types, and system utilization; however, similar to the Jefferson County dataset, it does not include critical time-based performance metrics such as response times, on-scene times, transport intervals, or hospital turnaround times due to CAD reporting limitations. As a result, a direct quantitative analysis of these time intervals is not possible. Despite this limitation, meaningful conclusions can still be drawn by applying national and Pennsylvania EMS benchmarks to the known system characteristics and call distribution, allowing for an informed evaluation of likely performance and opportunities for improvement.

Potter County EMS handled 4,453 total calls across the reporting period, with a mix of ALS medical (2,058 calls), BLS medical (1,081 calls), and BLS transfers (657 calls) representing the majority of system utilization. This distribution is consistent with local and national rural EMS trends, where the majority of responses involve medical complaints and interfacility or routine transports rather than high-acuity emergencies. The relatively high volume of transfers, in particular, reflects that a significant portion of EMS unit time is spent on non-emergency transport activities, which can influence response availability and prolong total unit hours committed per call compared to systems with lower transfer demand.

Although specific response time data is unavailable, typical rural EMS systems in Pennsylvania and across the United States operate within established benchmarks that provide a reasonable comparison. In rural regions similar to Potter County, turnout times generally range from 5 to 10 minutes depending on volunteer or combination staffing, while response times (dispatch to arrival) typically fall between 12 and 20 minutes. Based on Potter County's relatively low call volume and dispersed geography, it is likely that response times align with the higher end of these ranges, particularly in areas served by lower-volume agencies. Similarly, on-scene times for medical calls are typically 15–20 minutes nationwide and given the prevalence of ALS and BLS medical calls in Potter County, it is reasonable to infer that on-scene intervals fall within this standard range, reflecting appropriate patient assessment and stabilization practices.

Transport times in Potter County are also likely consistent with rural norms, generally falling between 15 and 30 minutes depending on distance to receiving facilities. The presence of a notable number of transfer calls suggests that EMS units frequently transport patients to facilities outside the immediate service area, which may contribute to longer average transport times compared to more urban systems. While these times are largely driven by geography and hospital access, they can have a significant impact on total unit hour utilization and overall system efficiency.



As seen in other county data sets, one of the most important performance considerations, despite the absence of specific data, is hospital turnaround time. Based on national patterns and the call mix in Potter County, it is likely that hospital time represents a significant portion of total call duration, especially given the high number of medical and transfer cases. Nationwide, acceptable hospital turnaround times are generally considered to be in the range of 20–30 minutes, but many systems experience delays exceeding this due to emergency department crowding, triage bottlenecks, and patient flow constraints. Given Potter County’s rural setting, delays may be less severe than in urban systems, but limited hospital capacity and staffing can still create significant offload delays, particularly during peak periods.

There are several clear opportunities to improve efficiency and reduce hospital turnaround time in Potter County. One of the most effective strategies is the implementation of formal offload agreements. These agreements improve accountability and encourage hospitals to prioritize EMS patient handoff. Additionally, introducing rapid handoff protocols using standardized formats can streamline communication and allow EMS crews to transfer care more quickly without waiting for full bed assignment or completion of hospital intake processes.

Another important strategy involves developing alternative patient flow options, particularly for low-acuity patients. Given the high number of BLS medical calls and transfers, Potter County would benefit from exploring community paramedicine programs, treat-and-release protocols, or transport to alternative destinations such as urgent care or behavioral health facilities. These approaches, which are increasingly supported within Pennsylvania EMS protocols, can reduce unnecessary emergency department utilization and indirectly improve turnaround times by decreasing ED congestion.

Operational improvements within EMS agencies can also contribute to reduced hospital time. These include ensuring efficient post-call processes such as equipment decontamination and restocking, minimizing delays before units return to service, and improving coordination between dispatch and crews regarding hospital status. Some systems also implement real-time hospital status monitoring, allowing crews to select the most appropriate destination facility based on crowding and expected wait times when clinically appropriate.

From a broader system perspective, collaboration between EMS agencies, hospitals, and regional EMS councils is critical. Regular data sharing and performance review meetings can help identify system bottlenecks, track hospital turnaround trends, and implement targeted improvements. Even without detailed time data currently available, establishing better data collection processes should be a priority, as accurate measurement of response, on-scene, transport, and hospital times is essential for long-term system optimization.



In summary, while Potter County’s dataset does not include direct time interval metrics, its call profile aligns closely with national EMS trends, suggesting that response, on-scene, and transport times likely fall within expected rural ranges. The greatest opportunity for improvement lies in reducing hospital turnaround time, which can be addressed through offload agreements, streamlined handoff processes, alternative care pathways, and stronger EMS–hospital collaboration. By focusing on these strategies and improving data tracking capabilities, Potter County can enhance system efficiency, increase ambulance availability, and maintain high-quality patient care consistent with Pennsylvania and national EMS standards.



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Appendix G – EMS Data Processing and Preparation Method of Procedure



1. Purpose

This method of procedure establishes a standard method for preparing, cleaning, and analyzing EMS agency data to ensure accuracy, consistency, and reproducibility across all agencies in the six-county regional assessment.

2. Scope

This procedure will be applied to all datasets by all responsible for processing EMS agency datasets, calculating performance metrics, and preparing data for analysis and reporting.

3. Roles and Responsibilities

Project Manager

- Ensure analysts follow this method of procedure.
- Approves final datasets and resolves data anomalies requiring judgment.
- Oversees QA review and signs off on completed agency files.

Data Analyst

- Executes all steps in this method of procedure.
- Documents issues, anomalies, and corrections.
- Flags data inconsistencies requiring escalation.

Quality Assurance Reviewer

- Conducts independent review of cleaned datasets.
- Verifies formulas, formatting, and pivot table accuracy.
- Confirm that all QA checkpoints have been completed.

4. Procedure

4.1 Create a Clean Working Copy

- Copy all raw agency data into a new worksheet.
- Unhide all rows and columns in the original sheet before copying.
- Paste the full dataset into a new sheet named “**AgencyNameData.**”
- Insert column headings if missing.



4.2 Insert Calculated Columns

Add the following fields and format each as **Time (Hrs:mins:secs)**:

- Dispatch to Enroute Time = Enroute Time – Dispatch Time
- Enroute to Arrival Time = Arrive Time – Enroute Time
- Dispatch to Arrival Time = Arrive Time – Dispatch Time
- Transport to Hospital Time = At Hospital Time – Transport Time
- Out of Service / Time at Hospital = Clear Time – At Hospital Time
- Total Call Time = Clear Time – Enroute Time
- Did Not Crew = Identified using GIS data for calls marked “Did not go ENRT”

4.3 Clean Calculated Columns

For each calculated column:

- Filter for **#VALUE!** and delete those entries.
- Filter for **#####** and highlight the cells causing the error.
 - These represent negative time values and indicate erroneous data.
- Repeat for all calculated columns.

4.4 Apply Conditional Formatting

For **Enroute Time, Arrive Time, Transport Time, At Hospital Time**:

- Apply conditional formatting to highlight in **red** the following values:
 - “Did not go ENRT”
 - “Did not ARR”
 - “No Transport”

4.5 Identify and Color-Code Transport-Related Call Types

Filter **Call Type Description** for:

- Transport
- Transfer/Interfacility Alpha



- Transfer/Interfacility Charlie
- Transfer/Interfacility Charlie 1
- Transfer/Interfacility Delta

Then:

- Color-code these records **purple**.
- Remove calculated call-time values for these records to avoid skewing averages.
- Retain the records in the dataset.

4.6 Calculate 36-Month Averages

At the bottom of each calculated column:

- Insert =AVERAGE(cell range)
- Confirm the range includes the full 36-month period.

4.7 Identify and Resolve Duplicate Calls

For the **Call** column:

- Apply **Conditional Formatting** → **Highlight Cells Rule** → **Duplicate Values**.
- Filter by color to group duplicates.
- Review each duplicate set:
 - Update addresses if needed.
 - Delete duplicate entries, retaining one record unless otherwise directed.

4.8 Create Pivot Table

Using the cleaned dataset:

- Insert a Pivot Table using all fields in **AgencyNameData**.
- Add **Call Type Descriptions** and **Radio Number**.
- Set values to **Count** to summarize call volume.

5. Quality Assurance Checkpoints

The QA Reviewer must verify:



- All raw data was copied, and no rows/columns remain hidden.
- All calculated columns are present, correctly formatted, and free of errors.
- Conditional formatting is applied correctly to all required fields.
- Transport-related call types are color-coded and excluded from time calculations.
- Averages are calculated correctly and placed at the bottom of each column.
- Duplicate calls have been reviewed and resolved.
- Pivot table fields and counts match the cleaned dataset.
- All anomalies are documented and escalated if unresolved.

The QA Reviewer signs off only when all checkpoints are complete.

6. Document Control

- Revisions must be logged with version number, date, author, and summary of changes.
- Superseded versions must be archived according to policy.



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Appendix H – Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)



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Mobile Integrated Healthcare and Community Paramedicine (MIH-CP)



Insights on the development and characteristics of these innovative
healthcare initiatives, based on national survey data

Presented by the National Association of
Emergency Medical Technicians



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Mobile Integrated Healthcare and Community Paramedicine (MIH-CP): A National Survey

Over the past several years, two new types of patient care offered by EMS agencies have generated tremendous interest within EMS and the wider health care community. Called mobile integrated healthcare and community paramedicine (MIH-CP), many believe these innovations have the potential to transform EMS from a strictly emergency care service to a value-based mobile healthcare provider that is fully integrated with an array of healthcare and social services partners to improve the health of the community.

Though still evolving, MIH and CP programs operating around the nation are providing a range of patient-centered services, including:

- Sending EMTs, paramedics or community paramedics into the homes of patients to help with chronic disease management and education, or post-hospital discharge follow-up, to prevent hospital admissions or readmissions, and to improve patients' experience of care.
- Navigating patients to destinations such as primary care, urgent care, mental health or substance abuse treatment centers instead of emergency departments to avoid costly, unnecessary hospital visits.
- Deploying telemedicine to connect patients in their homes with caregivers elsewhere.
- Providing telephone advice or other assistance to non-urgent 911 callers instead of sending an ambulance crew.

To add to the EMS profession's understanding of the development, characteristics and status of MIH-CP in the United States, NAEMT conducted a comprehensive survey in late 2014 of the nation's currently operating MIH-CP programs.

This summary analysis reports the results of that survey, and the conclusions

that can be drawn from the data. Analysis was provided by our author team, which includes several of the nation's MIH-CP thought leaders, medical directors and MIH-CP program administrators.

Survey finds much enthusiasm, significant obstacles

The survey identified more than 100 EMS agencies that have worked diligently over the past several years to determine their communities' needs, build partnerships to launch these innovative programs and contribute to solving the key issues facing American healthcare.

The promise of these programs has garnered the attention of a broad spectrum of stakeholders, ranging from hospitals to physicians groups, private insurers and the Centers for Medicare and Medicaid Services (CMS). The interest has enabled some MIH-CP programs to secure grants to cover the initial development and operation of their programs. The largest and most well publicized funding came from the CMS Innovation Center, which awarded grants to several EMS agencies and their partners beginning in 2012 to study the effectiveness of MIH-CP programs in achieving the Institute for Healthcare Improvement's Triple Aim: improving the patient experience of care, improving the health of populations and reducing the per capita cost of healthcare.

Outside of the federal grants, other EMS agencies have been successful in securing grants from foundations, or in negotiating contracts with partners such as hospitals, Medicaid managed care organizations,

home health agencies, hospice agencies and private insurers. Those contracts may include payments for MIH-CP services based on fee-for-service, a per-patient or capitated fee, or other shared savings arrangements.

Yet most EMS agencies launching MIH-CP programs have and continue to fund these programs out of their existing budgets – a sign of their dedication but worrisome from a financial perspective.

Compounding these challenges, the newness of EMTs and paramedics taking on new responsibilities, albeit ones within their scope of practice as defined by state laws and regulations, has also raised concerns among some regulators, nurses and other health professionals who question whether EMS should be permitted to offer MIH-CP.

Data provides a national snapshot

To date, the data collected by this survey and analyzed in this summary represents the only compendium of information from the nation's currently operating MIH-CP programs. Respondents, who included EMS agency directors, medical directors, and MIH-CP program managers and practitioners, represent diverse communities and provider types, from 33 states and the District of Columbia.

NAEMT would like to thank the respondents who took the time to tell us about their programs. We would also like to thank NAEMT's Mobile Integrated Healthcare-Community Paramedicine Committee for developing the survey questionnaire, and our author team for generously providing their time and insights in analyzing the data.

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP): A National Survey



IMAGE PROVIDED BY KEVIN PIEPER/THE BAXTER BULLETIN

Community paramedics from Baxter Regional Medical Center in Arkansas provide post-discharge follow-up visits and connect patients to primary care.

Survey Targets

Between April and October 2014, NAEMT conducted a thorough search to identify MIH and CP programs in the United States. Sources included:

- ① An earlier NAEMT MIH-CP survey widely distributed in 2013 by NAEMT and several other national EMS organizations as part of the Joint National EMS Leadership Forum.
- ① Media reports and Google searches.
- ① Other written materials, such as white papers and research studies, that referenced MIH or CP programs.
- ① Interviews with EMS industry contacts.
- ① Information provided by state EMS offices.
- ① Phone calls and emails to individual EMS agencies.

To determine inclusion as an MIH-CP program, we used the definition for MIH-CP contained in the MIH-CP Vision Statement, spearheaded by NAEMT and endorsed by more than a dozen national EMS and emergency physicians' organizations in 2014. The Vision Statement defines MIH-CP as being fully integrated; collaborative; data-

driven; patient-centered and team-based. Examples of MIH-CP activities can include, but are not limited to, providing telephone advice instead of resource dispatch; providing chronic disease management, preventive care or post-discharge follow-up; or transport or referral to care beyond hospital emergency departments.

Because there is no strict definition of MIH-CP, however, we had to make judgment calls about inclusion. For example, one EMS agency in a remote mining area of Alaska indicated they utilized telemedicine to connect patients with physicians in larger cities; this agency was not included because the goal was to provide assistance with acute situations, not education, preventive care or assistance with chronic disease management. We also did not include EMS agencies that described a high level of community involvement, such as providing community education on accident or falls prevention, teaching CPR, or conducting health screenings, but did not include any of the other elements of MIH-CP.

Questionnaire covers all aspects of MIH-CP

The survey was crafted with the input

of the NAEMT MIH-CP Committee and included more than 50 questions asking respondents to describe all aspects of their MIH-CP program, including program activities, partners, agency demographics, medical direction, funding, revenue, goals and data collection.

In September and October 2014, the survey was distributed to approximately 150 agencies that were either known or thought to have an MIH-CP program. During that time, NAEMT continued to do outreach to refine the list of agencies with confirmed MIH-CP programs.

As of November 2014, we received a total of 137 responses. Of those, 26 did not have MIH-CP programs; 111 did. Two did not provide any identifying information and were eliminated; two were significantly incomplete and could not be used. Four were duplicate answers from the same agency, so only one from each agency was included, for a total of 103 completed surveys.

Based on our search, we can say with confidence that this represents the vast majority of MIH-CP programs nationwide at the end of 2014.

However, it should be noted that new programs are coming on board every month, so by now there may be more. Our search also yielded many programs reportedly in the final stages of development or awaiting final grant or regulatory approval, such as the dozen programs that are part of the California pilots slated for launch in the first half of 2015 and six programs slated to launch in Michigan, also this year. These were not included.



100+ Agencies in 33 States, Wash., D.C. and Counting: Who's Doing MIH-CP

Though the concept of community paramedicine had its start in rural areas, today mobile integrated healthcare and community paramedicine programs operate in a range of community types.

[COMMUNITY TYPES]

| Urban | 54%

| Suburban | 44%

| Rural | 36%

| Super rural | 13%

About half (53 percent) of MIH-CP programs launched in the past year. Only 20 percent have been in operation two years or longer.

[TIME IN OPERATION]

| < 3 months | 10%

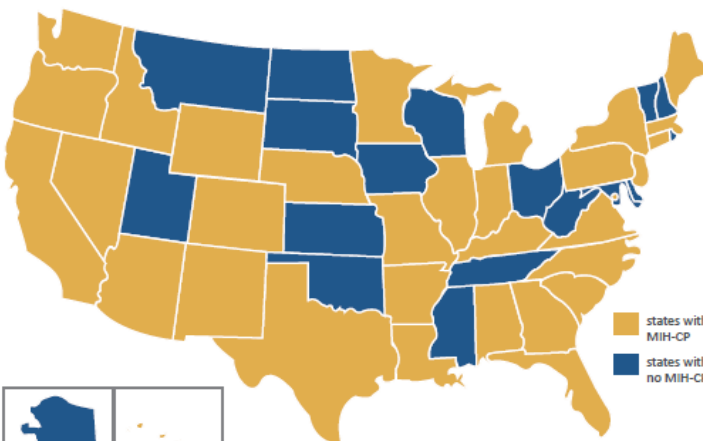
| 3-6 months | 16%

| 6 months - 1 year | 28%

| 1 - 2 years | 26%

| 2 - 3 years | 8%

| > 3 years | 13%



[RESPONSES]

Total number of MIH-CP program responses: 103

**Information about MIH-CP in Alabama came in after the survey concluded.*

Agency geographic service areas range from compact cities to sprawling rural and super rural regions.

[GEOGRAPHIC AREA COVERED]

| Less than 250 square miles | 35%

| 250 to 1,000 square miles | 35%

| More than 1,000 square miles | 29%

| Don't know | 1%

Call volume is also divided among high-volume urban and low-volume rural EMS.

[CALL VOLUME]

| Less than 250 square miles | 35%

| 250 to 1,000 square miles | 35%

| More than 1,000 square miles | 29%

| Don't know | 1%



The Important Role of the Community Needs Assessment

There is broad consensus within EMS that MIH-CP programs are not one-size-fits-all, but should be developed to meet community needs. It's also widely accepted that MIH-CP programs should not duplicate

or compete with already existing services, and

instead fill gaps in existing services. The way to determine where those gaps are is through a community needs assessment as part of the MIH-CP planning process.

While that premise seems self-evident, "community needs assessment" is a term more familiar to public health professionals than first responders, and may mean many things to many people. The survey sought to describe the nature and source of community needs assessments within operating MIH-CP programs.

According to survey responses, three in four agencies (77 percent) report conducting a community needs assessment.

Yet when a question about conducting a

community needs assessment was asked in a slightly different way – whether they agree or disagree with the statement, "Your program is based on a formal community needs assessment" – the responses were somewhat different. Only half (51 percent) agreed, 25 percent were neutral, and 21 percent disagreed. This perhaps indicates confusion over what constitutes a "formal" versus an "informal" community needs assessment.

Sources of data, stakeholder input

Of agencies that conducted a community needs assessment, the most commonly used data source is EMS data (87 percent), followed by population demographics (63 percent), hospital discharge data (55 percent), emergency department data (54 percent), public health data (41 percent), other data (12 percent), and law enforcement data (11 percent). Only 2 percent of agencies say they used no external data.

When asked to describe their community assessment, many agencies report having meetings, roundtables and establishing working groups or steering committees involving a variety of stakeholders, including hospitals, social services, mental health, law enforcement, assisted living facilities, public and private payers and public health departments.

MIH-CP programs should strive to reach patients before they become frequent users

Based on this survey, EMS agencies engaged in MIH-CP rely predominantly on data from individuals who utilize EMS services or have been cared for by the hospital system. This focus may hinder the MIH-CP system from gaining a full understanding of the needs of their community, such as individuals who have not accessed the 911 or hospital system but who may have significant care needs. As MIH-CP continues to develop, a long-term goal may be to reach members of the community before their health or psychosocial issues have deteriorated to the point where they become frequent users of hospitals and EMS systems.

Programs in existence for over two years were more likely to use a wider variety of data in assessing community need.

A narrow focus on patients already on the radar of hospitals and EMS may also restrict available payer sources. While focusing on this group of patients offers the opportunity for a "cost savings" source of revenue, it misses other potentially reimbursable patient encounters from the large pool of individuals who have not been hospitalized.

To identify these patients and gain a more complete look at community needs, MIH-CP systems should strive to use as many data sources as possible to identify the needs of a much broader population within the community.

It's worth noting that programs in existence were more likely to use data other than EMS data – 86 percent used population demographics, 62 percent used public health data, 62 percent used emergency department data, 19 percent used law enforcement data, and 19 percent used other data – suggesting that longer-duration programs use a broader set of community health data when evaluating healthcare gaps in their community.



Medical Direction Involves **Multidisciplinary Collaboration**

In emergency response, the role of the physician medical director is to ensure quality patient care. Responsibilities include involvement with the design, operation, evaluation and quality improvement of the EMS system. The medical director has authority over patient care, and develops and implements medical protocols, policies and procedures.

The role of medical direction in MIH-CP is in some ways similar, with protocol development (88 percent) topping the list of responsibilities. However, because MIH-CP focuses on coordinating care over a longer period than the typical EMS call, medical direction in the MIH-CP context may include additional responsibilities, often done in collaboration with primary care or other healthcare providers outside of the EMS agency. That can include the development and approval of care plans (62 percent), phone consultations (64 percent) and telemedicine consultation (18 percent).

EMS Medical Director Role

- 88%** Protocol development/ approval
- 64%** Phone consultation
- 62%** Development/approval of care plans
- 42%** Guidance on alternative destinations
- 18%** Live online telemedicine consultations

Hours of medical direction/ oversight provided per week

- Less than 10..... **79%**
- 10 to 20 **16%**
- More than 20..... **4%**

Others who provide medical direction and advice to MIH-CP programs

Primary care physicians (52 percent), on-call emergency physicians (29 percent) and specialty physicians (32 percent) are also called upon to provide medical direction or advice regarding MIH-CP patient care. Other sources of medical direction named by one or more respondents included other hospital physicians, physician assistants, surgical nurse practitioners, RN case managers and psychiatrists.



This collaboration is evident in the more than half (51 percent) of respondents who say that they obtained approval from partner organizations for their clinical protocols.

Breaking down silos: MIH-CP is team-based

From medical homes to care teams to accountable care organizations, the concept of collaborative, integrated, patient-centered care is a major theme of healthcare reform – and MIH-CP.

77% Agree that their program is a multidisciplinary practice of medicine overseen by physicians and other healthcare practitioners

70% Agree that their program is team-based and incorporates multiple providers, both clinical and non-clinical

96% Agree that their program is patient-centric and focused on the improvement of patient outcomes

1 in 4 agencies

report using telemedicine in their MIH-CP programs. It was not specified whether that involves specific telemedicine applications or more commonplace EMS activities, such as ECG transmission.

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP):
A National Survey



69%
of MIH-CP programs receive
referrals from hospitals

MIH-CP Programs Partner With an Array of Healthcare, Social Services Agencies

Mobile integrated healthcare by definition integrates with all entities that impact patient care and wellness. This integration is necessary for multiple reasons.

Patients who have frequent contact with EMS and hospitals often have multiple medical problems, comorbidities and complex psychosocial circumstances. These health issues cannot be solved by a single entity, but instead require the expertise of a variety of healthcare providers, social services agencies and community resources. For EMS, these partnerships enable MIH-CP

programs to match each patient's needs with the right resource.

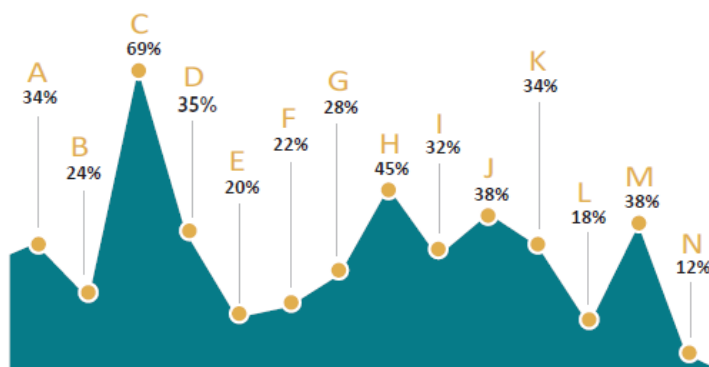
Referrals go both ways

Partnering works in two directions: the MIH-CP program can receive referrals from the partner agency, or the MIH-CP program can refer patients to the partner agency.

According to survey responses, hospitals are the most commonly cited source of referrals to MIH-CP programs, with 69 percent of MIH-CP programs reporting receiving referrals from hospitals, followed by

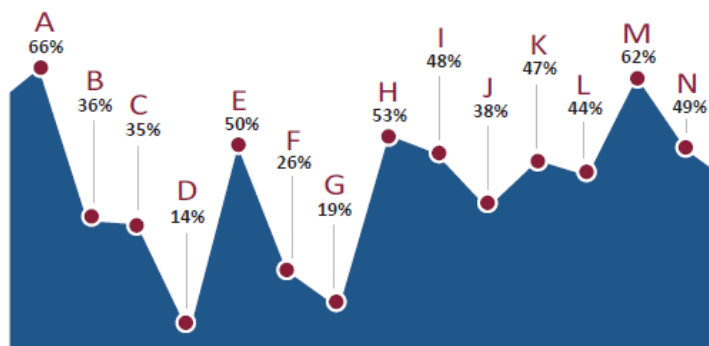
Organization Key

- A. Home Health Organizations
- B. Hospices
- C. Hospitals
- D. Law Enforcement Agencies
- E. Mental Health Care Facilities
- F. Nursing Homes
- G. Other EMS Agencies
- H. Primary Care Facilities
- I. Public Health Agencies
- J. Physician Groups
- K. Community Health Clinics
- L. Urgent Care Facilities
- M. Social Service Agencies
- N. Addiction Treatment Centers



[REFERRALS]

The partner organization refers patients to the MIH-CP program

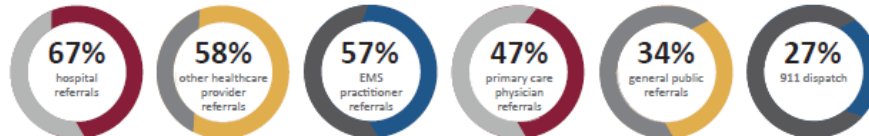


[REFERRALS]

The MIH-CP program refers patients to the partner organization



[SOURCES]
of MIH-CP program
enrollment



primary care facilities (45 percent), physicians groups (38 percent), social services agencies (38 percent), law enforcement (35 percent), home health (34 percent) and community health clinics (34 percent).

66%

of MIH-CP programs refer
patients to home health

In seeking solutions for their patients, MIH-CP programs are most likely to refer their patients to home health (66 percent), followed by social service agencies (62 percent), primary care (53 percent), mental health facilities (50 percent), addiction treatment centers (49 percent), public health agencies (48 percent) and community health clinics (47 percent).

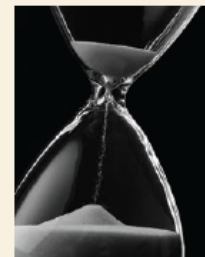
How patients come to the attention of MIH-CP programs

MIH-CP programs are made aware of prospective patients from a variety of sources. Hospital referrals are the primary portal to MIH-CP programs (67 percent), followed by referrals from other healthcare entities (hospices, home health care, mental health care and others) at 58 percent and primary care physicians (46 percent).

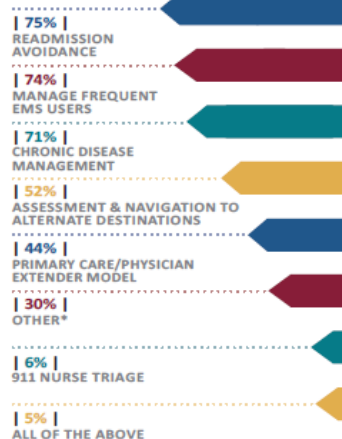
EMS sources, including referrals from fellow EMS practitioners (57 percent) and dispatch (27 percent) are also important in making MIH-CP programs aware of potential patients.

Awareness of the value of MIH-CP programs appears to grow over time

When isolating the data for programs with two or more years of experience, fellow EMS practitioners become the most likely to refer to MIH-CP programs (81 percent). While hospital referrals remain strong at 67 percent, referrals from other healthcare providers now come in at 71 percent, followed by dispatch and primary care, both at 52 percent. The increased percentage of referrals from nearly all sources may indicate that over time, EMS practitioners and other healthcare providers accept MIH-CP and see the value it can bring.



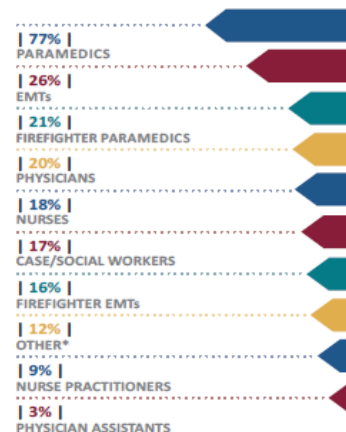
[CHARACTERISTICS OF MIH-CP PROGRAMS]



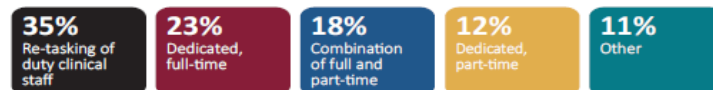
* mental health, hospice support, fall prevention

[STAFFING]

Respondents report employing or contracting with many types of practitioners for MIH-CP programs



* pharmacists, crisis counselors, patient navigators, residents, physical and occupational therapists



[MIH-CP CLINICAL STAFFING MODEL]

Some MIH-CP practitioners are dedicated full-time to MIH-CP; others split their time between MIH-CP and emergency response or other duties.



Partnerships Are About More Than Referrals

Partnering with stakeholders is not only about referrals. Some partners provide financial support, which may include direct payments for services, but can also include

assistance with staffing, supplies or other resources, while others provide oversight and direction to MIH-CP programs.

[DIRECT FINANCIAL SUPPORT]

Who provides direct payments for MIH-CP services?



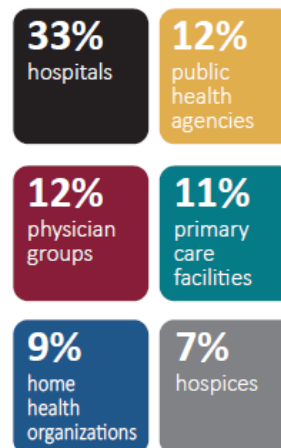
[OTHER FINANCIAL SUPPORT]

Who provides other financial support for MIH-CP services?



[OVERSIGHT/DIRECTION]

Who provides direction and oversight?



Is EMS doing everything it can to develop partnerships?

With more than half (54 percent) of respondents reporting that their programs are a year old or less, it is understandable that some may not have fully developed the necessary partners within their communities.

Still, more than half (58 percent) of respondents view their MIH-CP program as fully integrated into the healthcare system. Among programs in operation for two or more years, 66 percent agree that their program is fully integrated.

EMS agencies report challenges establishing partnerships for a variety of reasons, including:

- other healthcare providers not understanding the EMS role in an MIH-CP program
- fears among home health agencies that EMS participation in providing services in the home outside of answering 911 calls represents competition
- potential partners not seeing a clear financial incentive for partnering with EMS.

Though 34 percent of respondents agree that “opposition from other healthcare providers such as physicians, nurses or home health is a significant obstacle to sustaining or growing their MIH-CP programs,” an almost equal number (32 percent) disagree that opposition is a barrier.

And there is reason for optimism.

87% Agree that support for MIH-CP programs is growing among partners such as hospitals and other healthcare providers

96% Agree that the number of patients served by their MIH-CP program will grow in the next five years.



Experience Tops Qualifications Sought in MIH-CP Practitioners

61%
Developed
internally

20%
College-based

13%
Used another
MIH-CP pro-
gram's training

5%
Outside
contractor

[TRAINING PROGRAM DEVELOPMENT]

While the medical skills performed by EMS personnel participating in MIH-CP tend to be consistent with their emergency response training and experience, the *focus* and *context* of their clinical roles are very different. The practice of EMS is focused on rapid assessment, provision of resuscitative or supportive care within a narrow set of protocols, and transport to a hospital-based emergency department. In contrast, the practice of MIH-CP is focused on longitudinal assessment, participation in an existing, multidisciplinary, interprofessional treatment plan, and communication with and referral to other members of the treatment team based on changing patient needs. Contextually, care shifts from episodic evaluation and care of patients independent of their existing medical care plan to longitudinal monitoring and adjustment of care as a part of a medical care plan.

Asked what specific training or experience qualifications are required of MIH or CP employees, field experience was most often mentioned, with about one in four respondents specifying that MIH-CP practitioners had to have between one and 10 years of field work experience (usually paramedic).

Smaller numbers mentioned communications skills, positive attitude and a customer service focus as specific candidate competencies. As for specific credentials, several stated that critical care transport paramedic training was required or preferred, while several stated other certifications were required, including EMT, registered nurse, nurse practitioner and social work.

A few require some college or a college-based community paramedic certification. About one in four answered there were no special requirements.

"Borrowed" training programs include: Eagle County Paramedic Services, Wake County EMS, MedStar Mobile Healthcare, Mesa Fire Department and FD CARES.

Training topics

Nearly all respondents require some type of additional training for their MIH-CP practitioners. Clinical topics (67 percent), patient relations/communications (66 percent), accessing community programs and social services (63 percent) and patient navigation (59 percent) topped the list.

Length of training

The length of training varied widely, as did the inclusion of clinical rotations or field training hours.

[CLASSROOM HOURS REQUIRED]



[CLINICAL ROTATIONS/FIELD TRAINING HOURS REQUIRED]



Wide variations in training, education and certification requirements may jeopardize reimbursement opportunities

Overall, the survey data suggests that the majority of programs select experienced EMS practitioners for MIH-CP programs, and that they require additional training to perform these roles. However, the nature, duration and content of that training is widely variable, suggesting that the preparation, knowledge base and level of skill of EMS personnel who currently practice within MIH-CP systems is inconsistent.

This inconsistency could raise concerns among potential partners or payers about patient safety, clinical results or patient experience, and may reduce opportunities for reimbursement from payers who are more accustomed to well-defined and seemingly more clinically predictable providers of care.

EMS must continue to work toward creating consensus among stakeholders to define what MIH-CP clinical practice is, and from there create standards for skills, training, education and proof of competency.

Hennepin Technical College in Brooklyn Park, Minn. and Colorado Mountain College are the two most-often mentioned college-based training programs.



Clinical Services Seek To Avoid Unnecessary Emergency Department Visits, Hospital Stays While Improving Patient Quality of Life

The clinical services provided by MIH-CP practitioners can be broadly grouped into three categories that may be part of an ongoing health maintenance program, or as part of a goal directed therapy or lifestyle modification.

- 1 Assessment and evaluation
- 2 Post-discharge follow-up
- 3 Prevention and education

Common to all is that the MIH-CP program facilitates this without the requirement for a hospital or clinic visit, although the assessment may result in a recommendation to visit a clinic or other healthcare provider. The goal is always to direct patients to the most appropriate, convenient, least costly type of healthcare or social services provider qualified to take care of their needs.

1 Assessment and evaluation

While the vast majority of MIH-CP programs indicate they assess patients, the survey does not make clear what is being done with the information gathered, including whether clinical decision-making is autonomous, based on an algorithmic process or in consultation with the EMS medical director or other healthcare provider.

Assessment and evaluation encompasses multiple service lines, including general assessment, which most often includes history and physical (89 percent) and medication reconciliation (82 percent); along with laboratory tests and disease-specific care.

In-home lab services key to MIH-CP assessment and evaluation services

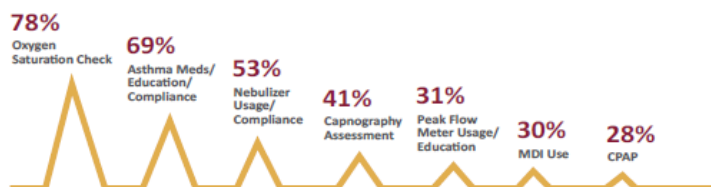
As with disease-specific care,

respondents were most likely to offer services that were already within the scope of practice of typical EMS agencies such as blood glucose measurement (70 percent) and blood draw services (41 percent). About one in five (19 percent) agencies report the addition of iSTAT (blood analysis) point of care testing. A surprising number of agencies had expanded their services to include urine collection (26 percent) stool collection (13 percent) and throat swab cultures (12 percent).

Disease-specific care relies on standard EMS equipment, skills

Disease-specific care offered by MIH-CP is most often targeted at common cardiovascular and pulmonary diseases such as congestive heart failure (CHF), chronic obstructive pulmonary disorder (COPD) and asthma. Most of these services utilize equipment and training readily available to EMS providers, such as blood pressure (85 percent), 12 lead EKG (70 percent) and oxygen saturation measurement (78 percent).

[RESPIRATORY SERVICES]



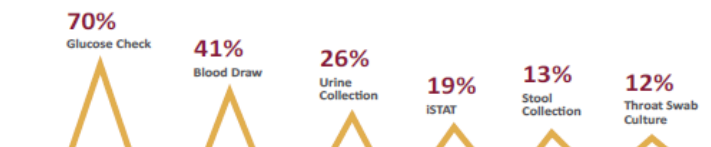
[CARDIOVASCULAR SERVICES]



[ASSESSMENT AND EVALUATION SERVICES]



[LABORATORY SERVICES]





The important role of patient navigation

While many of the clinical MIH-CP services provided seem directed at managing patients at home, the number of patients that can be meaningfully impacted and the cost effectiveness of this approach remain to be proved. Another area where MIH-CP may have significant impact on patient outcomes and costs is through improved patient navigation, or the direction of patients to the appropriate resource.

59% provide practitioners with training in patient navigation

EMS agencies should make effective use of their unique role in the healthcare system. EMS is often patients' initial contact with healthcare. Patients may not know the optimal resource for their current clinical need. Yet they do know that they can call 911 when they need help and EMS practitioners will come to their aid, quickly. These patients represent an opportunity for EMS to have meaningful impact on healthcare costs by navigating each patient to the correct resource at their initial contact with the healthcare system.

That said, it's important to note that the ultimate goal of MIH-CP is not merely to move the burden of caring for patients to other parts of the healthcare system, but to help patients get on the road to self-management, and better health and quality of life so that they need fewer healthcare resources overall.

63% of MIH-CP programs provide practitioners with training in accessing community programs and social services

Some MIH-CP programs, however, have significantly expanded their assessment and management of these disease processes beyond what EMS would typically do. For example, at least one program indicated that they offered in-home diuresis of CHF patients. For pulmonary disease, more than half of respondents indicated they offered education related to asthma medication compliance (69 percent), nebulizer use (52 percent) and peak flow meters (31 percent).

2 Post-discharge follow-up

Given the financial ramifications of extended hospital stays for non-acute care and the financial penalties assessed on hospitals with high rates of readmissions, follow-up visits in the home in the hours or days after hospital discharge is a potentially important way for MIH-CP programs to show value. Still, the data suggests some uncertainty about the specifics of the services delivered – for example, 44 percent of respondents say they do stroke assessment and follow-up, while only 27 percent said they do neurologic assessments.

3 Prevention and education

Prevention and education play an important role in preventing the next unscheduled acute care event or 911

call. MIH-CP practitioners are highly involved in providing these services to their communities.

[POST-DISCHARGE FOLLOW-UP SERVICES]

70% | Discharge follow-up

38% | Dressing changes/wound check

31% | Post-surgery care

27% | Neurological assessment

[PREVENTION SERVICES]

92% | Falls risk assessment

71% | Social evaluation/support

43% | Nutrition assessment

25% | Psychiatric assessment

[PATIENT EDUCATION SERVICES]

62% | hypertension screening/education

59% | diabetes screening/education

48% | physical activity screening/education

28% | Dietary sodium reduction

25% | Obesity screening/education

12% | Cholesterol screening/education

5% | Cancer self-exam awareness

How long do patients stay enrolled in MIH-CP programs?

The goal of MIH-CP programs is typically to "graduate" patients out of the program, which is often the point where they no longer rely on frequent contact with the 911 or hospital system. Often, getting patients ready for graduation first means getting them connected with primary care, mental healthcare providers and other services best equipped to take care of complex medical and psychosocial issues.

The average time patients are seen by MIH-CP practitioners is highly individual, with respondents reporting a range of less than 30 days (41 percent), 31 to 90 days (36 percent), 91 to 180 days (14 percent) and greater than 180 days (8 percent).

22% say their MIH or CP practitioners have an advanced scope of practice

77% say their MIH or CP practitioners do not



CASE STUDY

Tri-County Health Care EMS

Rural, hospital-based ambulance provider takes referrals from physicians to reduce readmissions, improve access to care

In 2012, Minnesota became the first (and still only) state to pass legislation authorizing Medicaid reimbursement of EMS-based community paramedics.

The rate is 80 percent of a physician assistant's office visit charge, or \$17.25 per 15-minutes of patient interaction. There is no payment for drive time, fuel or supplies.

To be seen by a community paramedic, a physician has to give an order, and it must be part of a care plan established by the physician. In December 2013, community paramedics at Tri-County Health Care EMS, based in rural Wadena, Minn., began



receiving referrals from hospital physicians and primary care physicians at the hospital's five rural clinics.

"We provide post-hospital discharge visits for patients at high-risk of readmission," says Allen Smith, Tri-County Health Care emergency response manager. "We also work with primary care physicians to help prevent unnecessary ambulance trips and emergency department visits and to ensure patients are accessing all of the health resources available to them in the community."

Tri-County community paramedics also work closely with the hospital's nurse care coordinator, and function as part of the hospital's "medical home" clinical team.

Help from grants

Funding for the program came from a Minnesota Department of Health grant, which sent five paramedics to the community paramedic course at Hennepin Technical College. A three-year, \$300,000 grant from the South Country Health Alliance, a Medicaid managed care organization that serves a four-county area, covers the cost of data analysis and staffing a community paramedic 24 hours a week. The hospital also funds community paramedic staffing for 24

hours, while the remainder comes out of the EMS budget.

To achieve 24-7 community paramedicine coverage, five community paramedics also answer 911 calls during their shift.

Starting small to prove safety, effectiveness

Prior to launch, Tri-County sought input from community partners, including public health, mental health, home health and members of the public. Wanting to proceed cautiously and build confidence in their program among physicians who they rely on for referrals, they started with a limited number of patients, Smith says.

The Tri-County team also worked with the hospital's electronic medical records software experts to enable community paramedics to access and input information into patients' medical records.

"Without that connection to the electronic medical record, the information would not get back to the physician. At our rural hospital, we use almost no paper charts," says Dr. John Pate, EMS medical director and a family practice physician.

Community paramedics aim to see patients within 24 hours of referral. Enrolled patients receive a home visit and



IMAGES PROVIDED BY TRI-COUNTY



“We have to show that what we do is making an improvement in patients’ health, their ability to have a good quality of life and that they are satisfied with the care received.”

— Allen Smith, Emergency Response Manager, Tri-County Health Care EMS

While EMS agencies in other states have reported conflicts with home health, this is not an issue in Minnesota, he says. “We are not home health. For patients to receive home health, they must have a payer source that covers it, and they must be homebound,” Smith says. “We see patients who don’t qualify for home health. We are also affiliated with a licensed home health agency, and we also refer patients there.”

Getting on a path to financial sustainability

Even though the only available reimbursement is for the 15 percent of patients who have Medicaid, Tri-County’s community paramedics see patients regardless of their insurance status. In 2014, reimbursements from Medicaid totaled about \$10,000 – not enough to cover costs. They hope to eventually have data to share with commercial insurers so that they can negotiate shared savings arrangements.

One challenge, however, has been deciding what data to collect and what outcomes to measure. Unlike urban areas, frequent users are not a big problem for the Wadena area. They do have a few though, and estimate that their community paramedic program saved \$100,000 in ambulance transport and

emergency department charges in 2014.

“A lot of the activities our community paramedics do involve checking up on patients. They might go out and see if an oxygen generator is working properly, or if they know how to use a nebulizer machine, or whether the medicine they have is what they were supposed to get,” Pate says. “In one case a gentleman was sitting there trying to use a nebulizer but he hadn’t turned on the machine. He would have ended up back in the ER. But how do you measure the impact of that? What is the true benefit?”

One strategy they plan to try is having patients fill out a quality of life questionnaire before and after enrollment. They will have their first results in the next six months.

“Part of our hospital’s mission statement is to achieve the Triple Aim, which is improving patient health, improving the patient experience of care, and reducing costs,” Smith says. “So how do I make sure my EMS agency is of value to my hospital? How do I ensure my people have jobs in the future? It’s no longer, ‘You call, and we haul.’ We have to show that what we do is making an improvement in patients’ health, their ability to have a good quality of life and that they are satisfied with the care received.”

assessment; a review of their care plan and education about managing chronic diseases; medication reconciliation; and any tests or treatments ordered on the care plan, such as blood draws, wound care or injections.

Patients are seen as often as daily for two to four weeks. The first visit is typically 60 to 90 minutes; subsequent visits last 30 minutes. Every two weeks, a multidisciplinary team, which includes a community paramedic, social worker and nurse care coordinator, evaluates each patient’s progress and determines if the patient is ready to graduate or needs additional help. “It’s all individualized based on the patient’s needs,” Smith says. “There is a lot of gray to this.”

In 2014, community paramedics saw 203 patients with diagnoses that include COPD, asthma, congestive heart failure and psychiatric issues. Most are elderly and need the extra support to continue to live independently, Pate says.

Other referrals come from an orthopedic surgeon, who sends community paramedics into the homes of knee and hip replacement patients to conduct falls risk assessments, and an area nursing home, which brings in community paramedics to do blood draws, tracheostomy care and feeding tube care to prevent their patients from needing to travel to a clinic or hospital.

Tri-County’s tips for success

- 1 **Start small** and gradually build acceptance of your program among physicians and other healthcare providers who you will need to provide your program with referrals.
- 2 **Think local.** “My program wouldn’t work in Ft. Worth, or in New York City, and their program wouldn’t work here. Your program needs to fit local needs,” Smith says.

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP):
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MedStar Mobile Healthcare paramedics conduct post-discharge home visits with patients in Ft. Worth.



80%

Agree that their programs are legally compliant at the local, state and federal levels



57%

Agree that statutory or regulatory policies are a significant obstacle to sustaining or growing their MIH-CP program



23%

Disagree that statutory or regulatory barriers get in the way of their MIH-CP program



Regulatory Barriers Pose Challenges

EMS is governed by laws and regulations that vary from state to state. In launching MIH-CP programs, one challenge for agencies is determining whether their state's statutes and regulations allow or prohibit EMS from engaging in MIH-CP.

Surveys of state EMS offices by the National Association of State EMS Officials (NASEMSO) indicate that in a large number of states, laws and regulations are interpreted as permitting MIH-CP; in others, statutory and/or regulatory language is interpreted as prohibiting it; while some have not yet interpreted their statutes. Anecdotally, EMS agencies frequently report that it can be hard to discern what, if any, MIH-CP activities their local regulations or their state attorney general would permit.

It is perhaps for that reason that more

than half of respondents (57 percent) see statutory or regulatory policies as obstacles to MIH-CP.

It should be noted these responses include only the states where there

“Don’t give up. It’s going to be one of the most difficult things you do as an EMS agency due to all of the regulations. If you remember this is the next step in helping the citizens of your jurisdiction and you repeat that to anyone who questions the program, you will maintain a positive attitude and be a champion for your program.”

— Survey respondent

are operating MIH-CP programs. In the states where there are no MIH-CP programs, prohibitive statutes or regulations, or perceptions of those, may be a reason why programs are unable to get off the ground. Another possibility is there isn't enough interest in MIH-CP yet.

Moving ahead with innovation despite barriers

Even in states in which regulations are seen as barriers to MIH-CP, some EMS agencies are finding ways to work within



the law to launch programs.

- ④ In California, state law says EMS must respond “at the scene of an emergency” and must transport patients to the hospital. But another statute permits pilot programs that use healthcare personnel in new roles to study improving patient outcomes and reducing costs. In mid 2015, about a dozen California EMS agencies are slated to launch community paramedicine pilots.
- ④ When Maine’s state EMS officials wanted to bring CP to the state, the Attorney General issued an opinion stating that the Maine EMS Board could not authorize community paramedicine because it is outside the scope of emergency response. The state legislature approved an amendment to the EMS statute authorizing 12, three-year CP pilots, which are currently underway.
- ④ In Michigan, the state EMS office determined their state laws did not prohibit MIH-CP. After consulting with the state Bureau of Legal Affairs, the EMS office determined that EMS agencies could apply for approval of CP programs via a “special study,” three-year pilots to test new healthcare strategies. So far, at least two programs have launched and six more are approved.
- ④ On the other end of the spectrum is Texas, a delegated practice state, meaning there is no statewide scope of practice for EMS. Instead, medical directors determine what EMS can do – perhaps one reason why Texas is considered a national leader in MIH-CP.

“Regulations must be updated to support this kind of work.”

– Survey respondent

What’s in the law that makes it difficult for EMS to take on these new roles?



While EMS is often described as being at the crossroads of public safety, public health and medicine (and so, perfectly positioned to provide MIH-CP), it is more common that EMS is more narrowly defined in law or regulation as an emergency service.

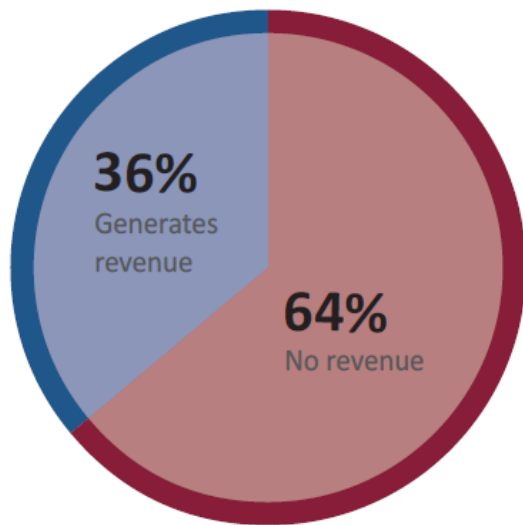
When asked to describe what legal barriers were hindering their programs, the most commonly cited issues were regulations that confine practice to 911 emergency response. Several mentioned there is no legal ability to transport patients to destinations other than the emergency department.

Home health licensing laws were also mentioned by several respondents. In conducting scheduled, in-home visits, there is the potential for MIH-CP services to be interpreted as falling under home health regulations. In Colorado, some MIH-CP programs have sought home health licenses, while one respondent from Virginia noted that the state Office of the Attorney General issued an opinion that MIH-CP programs wanting to perform in-home services should seek home health licenses.

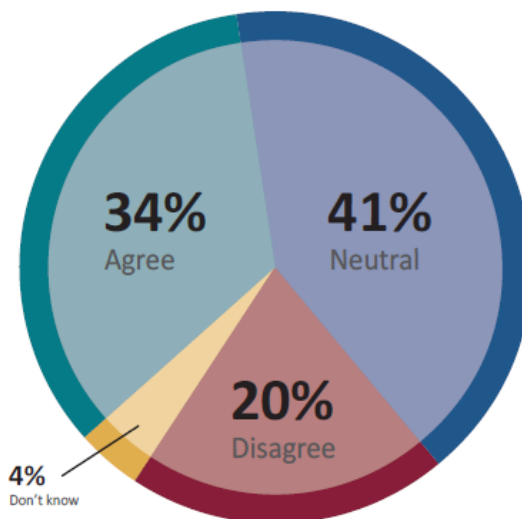
A few also mentioned the lack of clarity in the law, confusion over which regulatory body should have jurisdiction over EMS practitioners when acting outside of the 911 response capacity, difficulties working with city and state attorneys and hospital legal counsel, and questions about whether MIH-CP activities are within the paramedic/EMT scope of practice.



Limited Funding, Reimbursement for MIH-CP Makes Long-term Outlook Cloudy



[ARE MIH-CP PROGRAMS GENERATING REVENUE?]



[IS YOUR MIH-CP FINANCIALLY SUSTAINABLE?]

Reimbursement for transport and mileage is the bread and butter of EMS agencies. While public organizations, such as fire departments, often receive substantial tax support to fund operations, even these organizations say they are increasingly reliant on billing Medicare, Medicaid and private insurance to keep up with the increasing volume of medical calls.

When it comes to MIH-CP, however, there is only one state in which community paramedicine is a billable service, and even there it's only for patients with Medicaid. [See Tri-County Health Care Case Study]. Unable to bill for services, the vast majority of EMS agencies operating MIH-CP programs say the lack of payments and reimbursements is an obstacle.

89% Agree that reimbursement/funding is a significant obstacle

Yet respondents were not entirely pessimistic about their financial prospects. When asked if they agree or disagree with the statement "Your program is financially sustainable," the most common answer was "neutral," perhaps indicating that many are simply unsure.

Few MIH-CP programs generate substantial revenue – Yet

While many agencies fund their programs out of their own operating budgets, some have secured contracts that provide payment for MIH-CP services. Of the 99 respondents who answered the revenue questions, 36 – about one in three – report that their program generates revenue. For the most part, the revenue is minimal.

Seven receive under \$10,000 annually; four report earning between \$10,001 and \$25,000; and one generates between \$25,001 and \$50,000.

A few MIH-CP programs bring in considerably more. Four report earning between \$50,000 and \$100,000 annually; two bring in \$100,000 to \$150,000 annually; two receive payments of \$300,000 to \$500,000; and two generate \$500,000 or more annually.



A Wake County (N.C.) EMS advanced practice paramedic conducts outreach.

Economic model for MIH-CP payments

When asked how the MIH-CP program receives payments, the most common answer was fee-for service (15 agencies, or 15 percent). Eleven agencies indicate they receive an enrollment

50%
of respondents believe their program will continue to grow as a source of revenue for their EMS agency

fee or fee-per-patient, 12 say they operate in a shared savings model with partner organizations, and two say they receive a fee for referral. Twenty-three respondents indicated they were receiving other sources of revenue, with grants most commonly cited.

Is the financial outlook more promising than these early revenue figures suggest?

In the overall cycle of testing new business models, it is very common for innovations to take years to generate enough revenue to be considered a financial success. This is especially true in healthcare, where EMS-based MIH-CP services are still in their infancy. It is also very typical for healthcare innovations to take years to generate enough outcome data to become recognized as a valuable service line for payers to invest in. Healthcare payment policy is not often considered nimble.

For most EMS agencies, CMS (Medicare and Medicaid) represents the lion's share of revenue derived from fee-for-service transports, and making major changes in CMS payment policy literally require an act of Congress. Compounding this issue, most commercial payers generally follow CMS guidelines for payment policy. Therefore, it is not surprising that the revenue rates are so low during this time of innovation incubation.

It should also be noted that there are other potential sources of revenue outside of direct payments for services, including taxpayer support. Agencies that rely on tax revenue for a portion of their budget may have their programs funded, in whole or in part, through tax dollars if the community values the MIH-CP services or sees MIH-CP services as an overall means of cost savings.

Yet these survey findings also underscore the urgent need to prove that value – to the community, to private insurers, to CMS and to other entities that may provide payments. For insurers or other external sources of payments, demonstrating value will likely include showing a reduction in expenditures coupled with effective patient outcomes and positive surveys of patient experience.

[ANNUAL OPERATING COSTS OF MIH-CP PROGRAMS]



Mobile Integrated Healthcare and Community Paramedicine (MIH-CP):
A National Survey



IMAGE PROVIDED BY ACADIAN

Acadian Ambulance

Private ambulance company partners with Medicaid managed care organization to improve pediatric asthma care

Acadian Ambulance, which serves 30 counties in Texas, 33 Louisiana parishes and one Mississippi county, is one of the nation's largest private ambulance providers, answering half a million calls for service annually.

In 2013, inspired by the work being done by MedStar Mobile Healthcare in Ft. Worth, Texas, Acadian decided to launch an MIH-CP program. The Acadian team started where many EMS agencies begin – by analyzing EMS data for frequent 911 users who might benefit from better navigation and a more coordinated approach to care.

Gaining experience with frequent users

Their search identified about 15 people in the Lafayette, La. area who were calling 911 at least once a week. Paramedics arranged home visits with them. Many had complex medical and mental health issues that required individualized solutions, says

Richard Belle, Acadian's mobile healthcare and continuing education manager.

For one elderly woman, medics arranged mail-order prescriptions to prevent her from calling 911 every time she ran out of her medications. They reduced trip hazards in her home, and worked with United Way to have a rotted staircase replaced and a railing installed. Another patient was a paraplegic who suffered from frequent, painful urinary tract infections but could not get in to see a urologist quickly enough, so he went to the emergency department. Acadian's medical director got involved to get him an appointment. The man no longer calls 911 with regularity.

Of those initial 15 patients, all but one has significantly curtailed their use of 911 and the emergency department, Belle says. "There is a small population of people out there who are system abusers, and many of them have substance abuse problems," he says. "But most are using 911 because they don't have a primary care provider, they don't have transportation to get to a primary care provider or to get prescriptions filled, or they just don't

know how to get plugged into community resources that are available to them."

Expanding to diabetes, pediatric asthma care

Encouraged by their success, Acadian began outreach to potential partners. The first pilot to come out of that was with a private insurer, which contracted with Acadian to do home visits with diabetic patients to cut down on emergency department visits. During the four-month pilot, Acadian medics provided education on managing diabetes, and supplied glucometers and test strips to those who didn't have them. Though early results showed patients A1C levels had improved, the insurer ended the pilot without explanation, Belle says.

About a year ago, Louisiana Healthcare Connections, a Medicaid managed care organization, began working with Acadian on a pediatric asthma intervention. Acadian's Chief Medical Officer Dr. Chuck Burnell worked with Louisiana Healthcare Connections' clinical team to develop protocols.

"Last summer, we were looking for



"After six months, we've seen better management of asthma for the children in this program. Their emergency room utilization has decreased and their medication compliance has improved."

— Lani Roussell, Quality Improvement Manager, Louisiana Healthcare Connections

a way to help our young members with asthma, which is particularly problematic due to environmental factors in our state. Asthma causes more hospitalizations than any other childhood disease and is the number one cause of school absences from a chronic illness," says Lani Roussell, Louisiana Healthcare Connections quality improvement manager. "Because of their reputation for quality service and technological innovation, we partnered with Acadian Ambulance on a pilot program to bring mobile healthcare to New Orleans area children with asthma. The mobile healthcare program identifies Louisiana Healthcare Connections members who have pediatric asthma and are at a high risk of emergency room utilization. Then over the course of four weeks, Acadian Ambulance's trained paramedics visit the member at home to conduct preventive screenings, perform an in-home risk assessment, and provide personalized health coaching on managing asthma."

Program set to expand further

Acadian has received referrals for 362 children. An unexpected challenge was that a high number (133) were unreachable; either the address and phone on record with the insurance company were incorrect, or the family didn't return calls, Belle says.

Thirty families refused to participate; 107 are considered "inactive" because the family expressed interest in participating and received one or more home visits but then became unresponsive. As of March 2015, 33 families had completed the program and graduated.

"After six months, we've seen better management of asthma for the children in this program. Their emergency room utilization has decreased and their medication compliance has improved,"

Roussell says. "Together, Louisiana Healthcare Connections and Acadian Ambulance are developing innovative ways to address pediatric asthma and making a lifelong difference in the health, education and happiness of Louisiana's children."

Today, 19 families are enrolled in the program; 14 have a first visit scheduled and 23 have expressed interest. Among participating families, the response has been overwhelmingly positive, Belle says.

Some of the "fixes" are relatively easy, such as explaining to one family that their asthmatic toddler should not sleep in a crib with two cats. Others are more difficult. Some families live in substandard housing with mold and pest infestations. "We do very little clinical care. Most of what we do is education and navigation of patients, getting them to understand that when their child starts to feel bad,

they need to contact the child's physician. Don't wait and then go to the emergency department," Belle says.

Moving toward financial viability

Acadian medics receive a fee per visit from the managed care organization. But it still costs Acadian more to administer the program than it recoups, Belle says. With the program slated to run until the end of 2015, next steps will be re-negotiating their fee with the managed care organization, adding more patient groups, and sharing their positive results with other potential partners.

"This program will be revenue generating for Acadian in the coming months," Belle says. "We are going to take these results to other hospital systems, and public and private payers as a proof of concept, and show them how much money they can save by doing this."

Acadian's tips for success

- 1 **Frequent user programs** are a good place for EMS agencies to start developing an MIH-CP program. The agency can use internal data, and can use any successes to demonstrate effectiveness to potential partners.
- 2 **Tap into your local community health worker network.** Community health workers, who may be volunteer or paid workers, typically have little medical training, but instead conduct outreach, provide social support, do informal health behavior counseling and provide basic health education or screenings to members of the community. In Louisiana, the community health workers network shared valuable information about community resources such as social services, non-profits and charitable organizations. Acadian mobile healthcare paramedics also attend community health worker monthly meetings.
- 3 **Understand that every patient group has different needs.** The children in the Medicaid pediatric asthma group, for example, had a pediatrician. So one goal was to get the family to rely on the primary care provider instead of the emergency department. In a frequent user group, however, many patients are likely to lack primary care access, posing a different challenge for the mobile healthcare team.

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP):
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Measuring Outcomes and Patient Satisfaction to Show Value

With healthcare entities increasingly expected to show that treatments and interventions are worth the price, developing systems of collecting and analyzing data is a high priority across the healthcare spectrum.

Traditionally, EMS hasn't been expected to collect or report performance data, with the exception of response times and resource deployment. But it's only a matter of time before major payers such as CMS and private insurers will expect EMS to transition, along with the rest of healthcare, away from strictly fee-for-service reimbursement and toward reimbursement that takes into account costs and outcomes – in other words, value.

90% of respondents say their MIH-CP program collects data

In the MIH-CP context, collecting and reporting data internally and to healthcare stakeholders is beneficial for two major reasons. First, data can prove to the EMS agency and partners that the program is having the desired impact. Second, if the program is not achieving the desired outcome, the data serves as the foundation for developing, testing and comparing alternate models and strategies.

Consistent with the importance of partnerships and collaboration in MIH-CP, 65 percent of respondents indicate that they share data with their MIH-CP partners. Fewer but still sizable numbers

64% collect pre-MIH-CP enrollment healthcare utilization, while 56% collect post-enrollment usage too

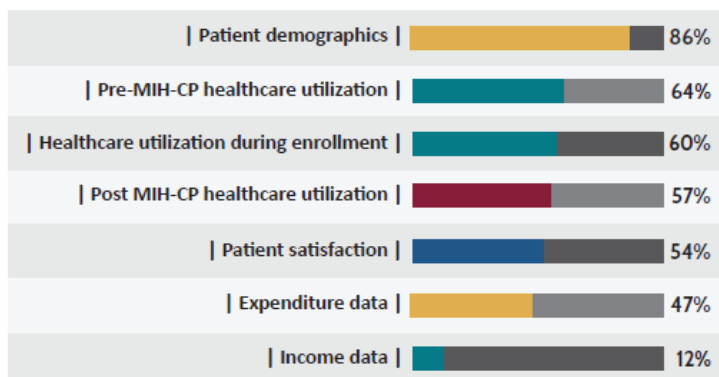
share with other entities, including local government or other local stakeholders (36 percent), their state Medicare/Medicaid office (21 percent), state public health department (20 percent), insurance companies (15 percent) and CMS (12 percent). Only 7 percent say they don't share data.

MIH-CP must grapple with what to measure and how to measure it

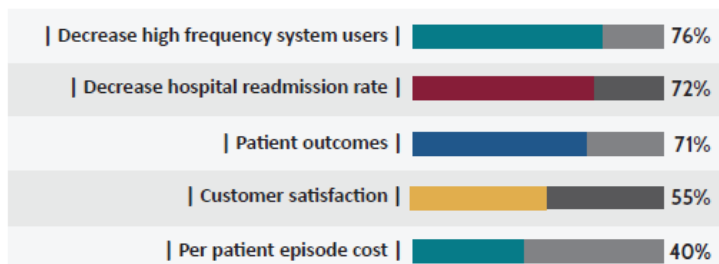
That so many respondents indicate they collect and analyze data for both MIH-CP program development and outcome measurement is very encouraging. This means that the basic infrastructure and commitment to tracking and reporting data is in place, a key step in demonstrating the value proposition that payers may want to see as a condition of widespread payments or reimbursement for MIH-CP services.

But determining the most important data to collect, the most feasible way to collect it and how to share it brings up complex questions that all of healthcare is grappling with – MIH-CP included.

[DATA COLLECTED BY MIH-CP PROGRAMS]



[OUTCOMES MEASURED BY MIH-CP PROGRAMS]





Community paramedics from North Memorial Ambulance Services in Robbinsdale, Minn. seek to prevent 911 calls.

IMAGE PROVIDED BY DAVID JOLIS/MINNEAPOLIS STAR TRIBUNE

In this survey, only one agency reports collecting and reporting patient health status as a core measure. Though the specifics of data collection may vary from agency to agency, the patient's assessment of their health status upon enrollment and at graduation is a key measure that should be used by all EMS agencies conducting MIH-CP programs.

In addition to challenges in determining which outcomes to measure, there are also technological obstacles, including the daunting inability of many electronic patient care reporting (EPCR) systems used by EMS to fully integrate with the data systems of hospitals and other partners, and vice versa. Another issue is that many EPCR systems used by EMS are not designed to collect longitudinal data. The incompatibility of various data systems and barriers to health information exchange is hardly exclusive to EMS or MIH-CP, but is an area that needs attention to make possible the bi-directional flow of information between the multi-disciplinary teams involved in MIH-CP.

EMS agencies describe strong early successes in reducing reliance on 911 and emergency departments

With the majority of programs in operation for a year or less, it's not surprising that one in four respondents say that it's too soon to tell how much success they are having in key areas such as reducing costs, reliance on 911, the emergency department and 30-day readmissions. Yet a sizable percentage say they are seeing success in a variety of areas.

54% Rate their program as highly or somewhat successful in showing cost savings for a defined group of patients

60% Rate their program as highly or somewhat successful in reducing 911 utilization among specific patient groups

59% Rate their program as highly or somewhat successful in reducing reliance on the emergency department for a defined group of patients

81%
of programs in operation for two years or longer report success in reducing costs, 911 use and emergency department visits for defined groups of patients

46% Rate their program as highly or somewhat successful in reducing 30-day readmissions for specific patient groups

62% Rate their program as highly or

somewhat successful in achieving patient satisfaction

With which groups of patients do MIH-CP programs report success?

MIH-CP programs are most likely to report success with frequent 911 users – 54 percent say they are highly or somewhat successful in improving outcomes for this group while 51 percent say they are highly or somewhat successful in reducing per patient healthcare costs.

One patient group that seems to be particularly challenging for MIH-CP programs is patients referred because of substance abuse or alcoholism. About 26 percent of MIH-CP programs report improving outcomes for this group, while 18 percent report lowered healthcare costs.

[MIH-CP Programs Report Improved Outcomes for Various Patient Groups.]

	Improved Outcomes	Too Soon To Tell	Not Applicable
Frequent 911 users	54%	0	16%
COPD, asthma, diabetes	54%	25%	17%
Congestive heart failure	37%	25%	30%
Substance abuse/alcoholism	26%	20%	35%
Hospice/terminal illness	26%	19%	44%

[MIH-CP Programs Report Lowered Costs for Various Patient Groups.]

	Lowered Costs	Too Soon To Tell	Not Applicable
Frequent 911 users	51%	29%	14%
COPD, asthma, diabetes	42%	33%	21%
Congestive heart failure	33%	33%	28%
Substance abuse/alcoholism	18%	31%	32%
Hospice/terminal illness	18%	29%	41%

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP): A National Survey



CASE STUDY

Colorado Springs Fire Department

Partnering with hospitals, Medicaid care coordination organization to reduce 911 calls

With medical 911 calls increasing by about 8 percent annually and data showing that about 50 percent of 911 responses are for non-urgent situations, Colorado Springs Fire Department, which answers 60,000 calls annually, wanted to find ways to redirect some of those callers to resources other than the emergency department.

As a first step, in 2012, the fire department, in partnership with University of Colorado Health-Memorial Hospital and Centura Health System's Penrose-St. Francis Hospital, set out to study the reasons underlying the overuse of 911 and emergency departments. Teams made up of a physician and an EMT or paramedic went into the homes of frequent 911 users to assess the patient and their home environment. The hospitals covered the

cost of the physician time, while a Kaiser Permanente grant covered data analysis.

"We told them to look, listen and connect," says Jefferson Martin, Colorado Springs Fire Department's community and public health administrator. "We quickly came to the determination that there was nothing acute medically that we needed to do during those visits." Instead, patients needed education about managing chronic diseases, lacked transportation to pharmacies or doctor's offices, or were in need of resources to assist with psychosocial or economic issues. "The easy button was 911. That system couldn't turn them away," he says.

Three months into their investigation, they determined that a physician wasn't needed for the assessments. Instead, they sent an EMT or paramedic with a nurse

or nurse practitioner, and eventually, only EMTs and paramedics.

Three in four have mental health issues

Over a one-year period, the teams visited 200 homes. Their analysis showed that three in four (77 percent) patients had mental health issues, often with other chronic medical conditions.

Calling their program CARES (Community Assistance Referral and Education Services), a name coined by Battalion Chief Mitch Snyder of Kent Fire Department in Washington, they launched a program in which EMTs and paramedics would continue the home visits, providing assistance with education and navigating patients to mental health or other community resources.

"This is about delivering the right care, at the right time, in the right place," says Dr. Robin Johnson, an emergency physician at Memorial Hospital who has since become a deputy medical director for CARES. "It is never about saying no to care, but about redirecting to the best healthcare for the patient."

With funding from Penrose-St. Francis Hospital, the fire department hired a licensed clinical social worker/behavioral health specialist to provide guidance and case management. The fire department also shifted the responsibilities of a nurse practitioner, already on staff as the fire department's quality assurance officer, to assist.

"In EMS, we are fixers," Martin says. "We don't think in terms of long-term behavioral modification, so it's great to have an expert to come in and help us. One thing we've been taught by the behavioral health specialist is that we don't want to enable or reward negative behaviors, so we are not supposed to do everything for patients. Instead, we set health goals that include steps they can take, and steps we can do for them. Our patients may have 10 issues that are contributing to the way they are accessing the system, but we try not to overwhelm



IMAGE PROVIDED BY COLORADO SPRINGS FD



them. We have to prioritize.”

Patients are seen at home up to five times. They are also given the phone number for a mental health crisis line that’s answered 24-7, and a number for non-urgent problems, which goes directly to voice mail. There’s a reason behind not having a live person answering those calls, Martin says. “Our behavioral health clinician has said we need to teach them how to plan ahead. The lesson is, ‘We will still help you, but not in 8 minutes or less,’” he says.

In 2013, the CARES program saw 200 patients. In 2014, they upped that to 500 patients – and are seeing results. Among two-thirds of patients, 911 use dropped by 50 percent.

agree to work together to improve care coordination for Medicaid patients. The RCCO pays the fire department \$1,000 per patient for a 90-day intervention, with a total of \$100,000 budgeted, and also covers the cost of a pharmacist to assist with medication reconciliation.

A pilot involving 13 patients found a 75 percent decrease in hospital readmissions during the three months post-intervention, an estimated cost savings of \$145,000 in Medicaid claims, says Kelley Vivian, the RCCO’s community strategies director.

“The CARES program is a wonderful way to interact with our clients that we refer to as super-utilizers – the well-known faces in the 911 system, the emergency department

with a nurse practitioner who respond to low-acuity (Alpha or Bravo) calls, and a Community Response Team, which includes a paramedic, behavioral health clinician and law enforcement officer who respond to 911 calls that are psychiatric in nature.

The state Office of Behavioral Health provided funding, while the medical directors of the fire department, emergency department and a psychiatric facility worked together to develop protocols that enable the team to do the exam, blood draws and toxicology screening necessary to medically clear patients in the field, without needing transport to an emergency department. Launched Dec. 1, 2014, the first call came in 8 minutes later, Martin says.

Other additions to the program include one full-time and three part-time nurse navigators, whose salaries are paid for through a combination of the fire department budget; grants from Aspen Point, a behavioral health organization, and Kaiser Permanente.

With so many healthcare and community entities seeing value in the CARES program, the RCCO, Vivian says, is considering increased funding for CARES next year.

“We think there are more clients who can be served. Firefighters are trusted, thorough and they do a good job of explaining what is going on in the home back into the system of care,” Vivian says. “We think this is a really great way of bringing hospitals, emergency services, a payer source and others together to address community needs, and that there will be payers in addition to Medicaid that will be interested in this.”

“We think this is a really great way of bringing hospitals, emergency services, a payer source and others together to address community needs, and that there will be payers in addition to Medicaid that will be interested in this.”

– Kelley Vivian, Community Strategies Director,
Colorado Medicaid Regional Care Collaborative Organization

The other third have been harder to reach, he says. “These patients are incredibly complex. For them it’s not about access to primary care, or education, or transport. Those are issues we can solve,” he says. “The patients we’ve been less successful in moving the needle on are those with medical, behavioral, mental health and substance abuse issues.” As a last resort, the CARES team will enlist the help of the legal system, including law enforcement and the court system, to compel a psychiatric evaluation or commitment.

Medicaid Regional Care Collaborative gets involved

Seeking a strategy to reduce costs among frequent emergency department users, the next organization to get involved with the CARES program was the Colorado Medicaid Regional Care Collaborative Organization, or RCCO, a non-profit made up of multiple area healthcare entities that

and even in their doctor’s office,” Vivian says. “These are patients that need that extra level of interaction, to help them become more proactive in their health and so they can take better care of their health.”

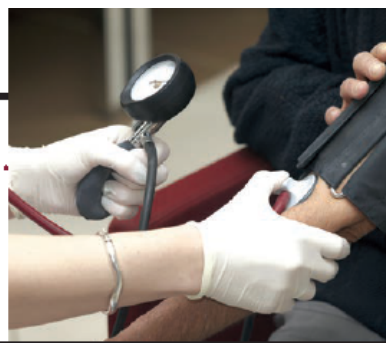
Program expands to include other teams

The next step for the fire department was expanding the program to include two additional units – a mobile urgent care unit, which includes a paramedic or EMT paired

Colorado Springs Fire Department’s tips for success

- 1 Conduct a thorough community needs assessment, for your own information and to present to partners. “Anecdotes are not enough,” Martin says.
- 2 Collaborate and seek guidance from pharmacists, licensed clinical social workers/behavior specialists and other healthcare specialties.

Mobile Integrated Healthcare and Community Paramedicine (MIH-CP):
A National Survey



Lessons Learned - Tips from the experts

One of the most revealing questions in the survey relates to lessons learned and advice respondents offered to other EMS agencies seeking to launch MIH-CP programs. The answers of the 86 respondents who offered their input can be summarized in seven themes.

1 Collaborate, don't compete. MIH-CP programs work in partnership with other healthcare stakeholders to fill gaps in healthcare delivery, not replace services already available within the community. The most oft-cited recommendation was to involve stakeholders early in the planning process.

"Early identification of stakeholders is essential ... make sure they are at the table from the beginning." – Survey respondent

"Develop a community stakeholders list and begin to have regular informative meetings." – Survey respondent

The purpose of early stakeholder consultation is to inform potential partners about MIH-CP, to share agency plans, to ensure the regulatory environment is understood at the outset, to allay fears of competition and to secure buy-in, according to respondents.

"Help stakeholders see that EMS is committed to better outcomes of population health and better stewardship of healthcare dollars." – Survey respondent

"Rather than view EMS as merely the 'ambulance drivers' that deluge a hospital, EMS should be seen as the critical link that is driving the dissolution of barriers to coordinated care." – Survey respondent

2 Do a community needs/gap analysis. Prior to launch, learn the resources that are available within the community, determine where there are gaps and find out if your EMS agency can have a role in filling those gaps.

"As every community is different, the most important component of program development is focusing on the specific needs of the population served and designing a program around them." – Survey respondent

"Although various programs may have common principles, the key to success is creating one that's right for your community's needs." – Survey respondent

3 Start small and build on success. Another common piece of advice was to start with a limited number of patients and build upon experience. Several also urged EMS agencies to avoid trying to address all needs simultaneously. They also encouraged patience and perseverance, saying that getting programs up and running always seems to take longer than planned.

4 Focus on the patient. Several respondents reminded EMS agencies to above all, keep the patient at the center of the program design.

"Always view this type of initiative in light of what is best for the patient, your community and then your organization. The incentives to begin these programs shouldn't be money as a primary factor. Collaborate, innovate, execute, retool, re-execute." – Survey respondent

5 Integrate. Integration with the existing healthcare system includes the gap and resource analysis highlighted above, as well as other integrations in health information technology, referral processes and patient navigation to the most appropriate care.

"We work closely with patient navigation to address non-medical, access, insurance, behavioral health and social needs." – Survey respondent

"Develop the network of resources you will need for the patients enrolled in the program." – Survey respondent

6 Collect Data. Another common theme was encouraging MIH-CP programs to collect data relevant to measuring patient outcomes, patient experience and impact on patient costs. Some emphasized the need to integrate with local, regional or state electronic health information exchanges (HIE).

"Join or create local HIE and share your data and interpret its significance for your patients, your system and primary healthcare and services providers." – Survey respondent

7 Learn from other MIH-CP programs. Multiple respondents also recommended consulting with established MIH-CP programs.

"Do not reinvent the wheel. There are a lot of resources available to study and emulate. Replicate best practices and learn from the agencies that have been running programs to help avoid potholes." – Survey respondent



Conclusion: What Will It Take for MIH-CP to Become a Success?

The growing movement to compel more efficient healthcare spending and the widely acknowledged need for integration and collaboration to solve complex patient issues represents an enormous opportunity for EMS to cement its future in a changing healthcare world.

This survey shows that through MIH-CP, many agencies are proactively redefining the role of EMS, from one associated mainly with emergency response to one involved with prevention, patient education and effective navigation. This is no small feat, given obstacles such as opposition from other healthcare entities; confusing and sometimes prohibitive legislative or regulatory barriers; and limited reimbursement.

Those obstacles are perhaps one reason why, out of an estimated 17,000 EMS agencies nationwide, only 100 or so have launched MIH-CP programs. And many of those agencies, despite their enthusiasm and strong belief that they are doing what's right for their communities and their patients, admit their long-term sustainability is by no means guaranteed.

How to define success?

Defining "success" for a healthcare program such as MIH-CP can be considered from multiple angles. For individual patients or groups of patients, success is defined by impact and costs, and measuring it is dependent on collecting and analyzing the sort of clinical and outcomes data discussed earlier in this summary analysis.

Success can also be considered from the EMS agency perspective, and could include



factors such as whether an MIH-CP program is revenue generating or self-sustaining; how the program impacts the EMS agency's relationships and reputation within the community; whether MIH-CP provides opportunities for professional growth for the EMS workforce; and the extent to which MIH-CP enables the agency to achieve its mission of serving its community.

A third way to look at success is at the macro level – that is, to what extent can MIH-CP impact patient outcomes and achieve sustainability on a large scale, nationwide? Although answering that question is premature, what can be discussed are the key factors that will contribute to the ability of MIH-CP programs to become firmly established as cost-effective, value-added healthcare service providers in the months and years to come.

Three key factors

1 State level statutory and regulatory change – Today, many state laws and regulations expressly limit EMS agencies to emergency or 911 response and limit their activities to providing medical care only at the scene of an emergency.



Through MIH-CP, many agencies are proactively redefining the role of EMS, from one associated mainly with emergency response to one involved with prevention, patient education and effective navigation.



Conclusion: What Will It Take for MIH-CP to Become a Success?

MIH-CP should be included in healthcare policy change and reimbursement reform that transition EMS into a value-based health services provider that is adequately funded to continue its vital role in safeguarding the health and well-being of our nation's population.



IMAGE PROVIDED BY MEDSTAR MOBILE HEALTHCARE

In practice, EMS practitioners know many 911 calls are not life threatening, and instead are patients who could be better served by less expensive resources, such as primary or urgent care. Moreover, the narrow view of EMS as emergency-only represents an outdated, siloed view of the provision of patient care that is rapidly falling by the wayside elsewhere in the healthcare system. The findings of this survey, along with the case studies, suggest that the narrow view of EMS is beginning to change among other healthcare providers as well.

2 Data proving value – The most powerful case for convincing payers or healthcare partners to invest in MIH-CP programs is to provide proof that the programs achieve the Triple Aim of improved patient experience of care, improved population health and reduced per capita cost of care.

Some MIH-CP programs have already secured contracts with hospitals, home health, hospice, nursing homes, Medicaid care coordination and managed care organizations, and even a state department of behavioral health. But to turn that trickle into a flood, EMS agencies need to engage in collecting, analyzing and reporting data.

In a positive sign, many MIH-CP programs say they collect data and are showing positive results. Yet there are almost no peer-viewed, published studies on MIH-CP outcomes. In addition, the EMS profession is still working toward a consensus on the best method for demonstrating value, including determining what to collect, how to report it and to whom.

3 Reimbursement reform – Today, EMS is paid via a transportation-based, fee-for-service model, specifically for delivering patients to an emergency department. “This provides a disincentive for EMS agencies to work to reduce avoidable visits to emergency departments, limits the role of prehospital care in the US health system, is not responsive to patients’ needs, and general downstream healthcare costs,” wrote Dr. Kevin Munjal in a Feb. 20, 2013 *JAMA* editorial. “Financial and delivery model reforms that address EMS payment policy may allow out-of-hospital care systems to deliver higher-quality, patient-centered, coordinated healthcare that could improve the public health and lower costs.”

Hospitals, physicians, and other medical providers are increasingly subject to value-based reimbursement, including receiving penalties for unnecessary hospital readmissions. Thus far, EMS hasn’t had its reimbursement tied to performance or outcomes measures, but it’s only a matter of time before CMS and private insurers will expect EMS to fall in line with the rest of healthcare.

Individual EMS agency contracts with hospitals and other healthcare partners will continue to be an important source of revenue to support MIH-CP programs. But MIH-CP should also be included in healthcare policy change and reimbursement reform that transition EMS into a value-based health services provider that is adequately funded to continue its vital role in safeguarding the health and well-being of our nation’s population.



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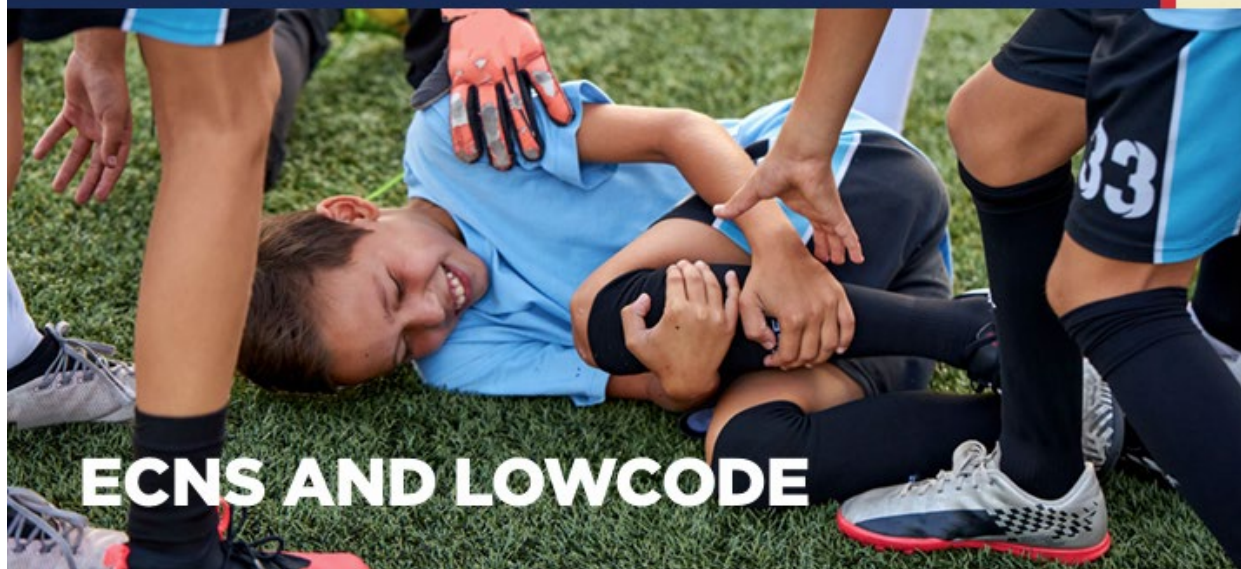


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Appendix I – ECNS (Emergency Communication Nurse System) & LowCode



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ECNS AND LOWCODE

ECNS PROGRAM

The Emergency Communication Nurse System (ECNS) is certified by the International Academies of Emergency Dispatch® (IAED™) as its Fourth Pillar of Care and is available to agencies with an ACE designation in the use of the IAED's Medical Priority Dispatch System™ to triage 911 calls.

The ECNS program has been (and still is) the pioneering program used to triage low acuity 911 calls in the international EMS market, since 2001. The then East Anglia ambulance service was the first adopter of this technology in the UK and has been using the technology uninterrupted for the last 19 years growing from a couple of LowCode workstations to where East of England Ambulance Service Trust currently are running 40 concurrent LowCode workstations during the COVID-19 pandemic. The ECNS system was first adopted by Richmond ambulance service in Virginia in 2004 followed by Medstar in Fort Worth Texas a few years later and a few more US based agencies followed subsequently including a flagship implementation at REMSA in Reno Nevada. ECNS was deployed country-wide in Austria (in German) in 2017 as well as in Wales in 2022.

ECNS is now used on four continents around the world (in 7 languages) to triage low acuity calls from the public in both the 911 sector and general telephonic triage sector.

Quality assurance and quality improvement is of utmost importance and therefore standards are set to ensure the safe and effective use of the tool.

Unlike competing products, it is a requirement for an agency to have the ACE designation in MPDS in order to utilize ECNS (should your agency not have an ACE designation currently, we will work closely with your agency to achieve this goal over the next few months). This ensures that only truly low acuity calls are sent for secondary triage and no undue delay is caused in responding to potentially more urgent cases.

The ECNS program has a very strong link to the current MPDS (primary triage product) used by your agency.

- The International Academy of Emergency Dispatch (IAED) is the clinical governance arm for both programs.
- The LowCode clinical decision software system has a proprietary link with MPDS on a code level enabling only a preselected set of codes to be triaged via ECNS, therefore preventing codes of a higher acuity accidentally be sent for secondary medical triage.
- Both triage programs are managed within the same building allowing for cross pollination between the programs on a clinical and technological level.
- Both programs use the AQUA clinical audit system to ensure standards are achieved and maintained.



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Appendix J – County Commissioners Association of Pennsylvania EMS Toolkits

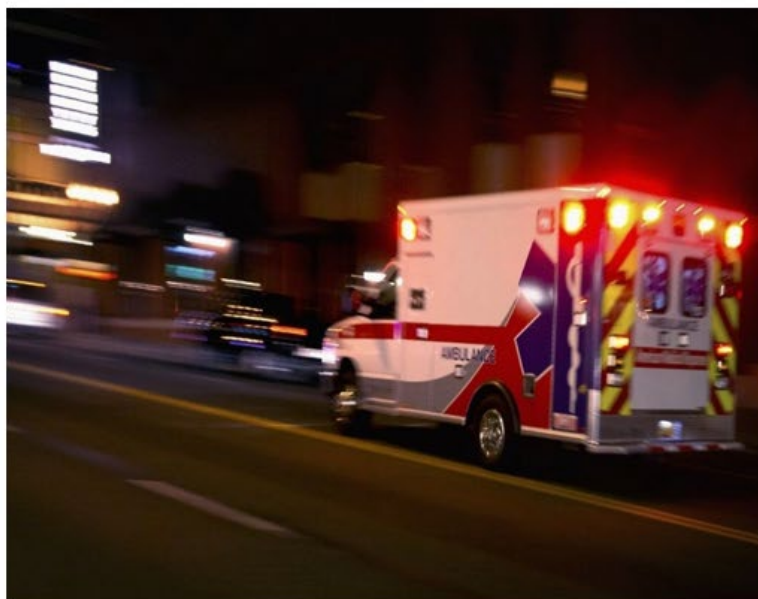


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Pennsylvania EMS Crisis



January 2023

Toolkit and Recommendations

TOOL #1

TRAINING AND CERTIFICATION: ACCESSIBILITY



EMS Tool Kit		Applicability:
Focus Group:	Training and Certification	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Accessibility	
Type:	Recommendations	

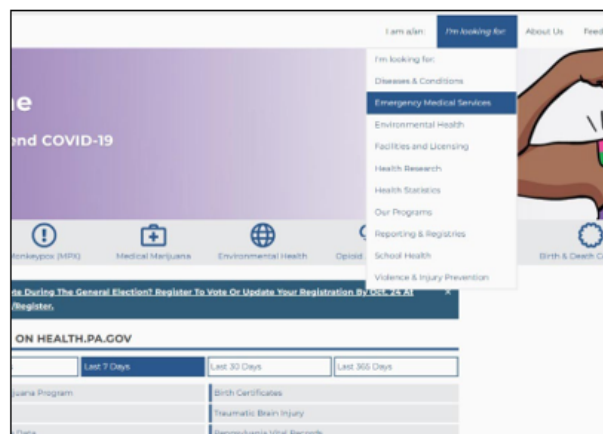
Introduction:

Training and certification of emergency medical services personnel can be generally divided into categories of initial certification and continued education and training. The certification requirements are outlined and well defined by the Pennsylvania Department of Health for each level of emergency medical services certification. However, information regarding location of, and registration for, initial certification courses is difficult to find. Routine internet search results do not provide straightforward access to sites that allow the user to locate or register for the intended course(s).

Discussion:

A search of the Pennsylvania Department of Health website results in returns of keyword articles and publications which are difficult to navigate. Individuals who are familiar with the intended content would find navigation through the returned information to be cumbersome and irrelevant. Prospective trainees without knowledge of applicable search terminology are unlikely to locate relevant links for requesting additional certification information.

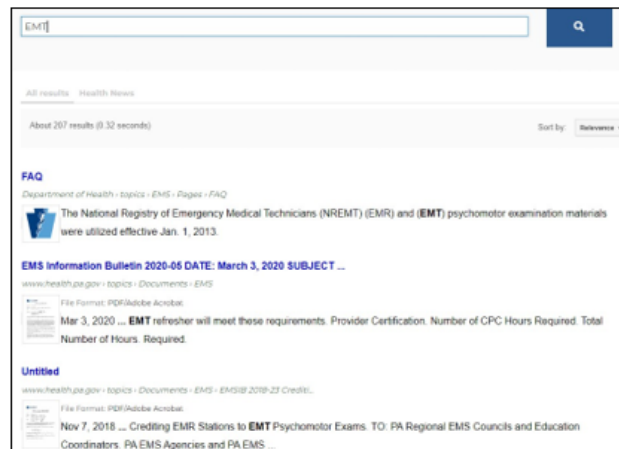
Figure 1 – www.health.pa.gov





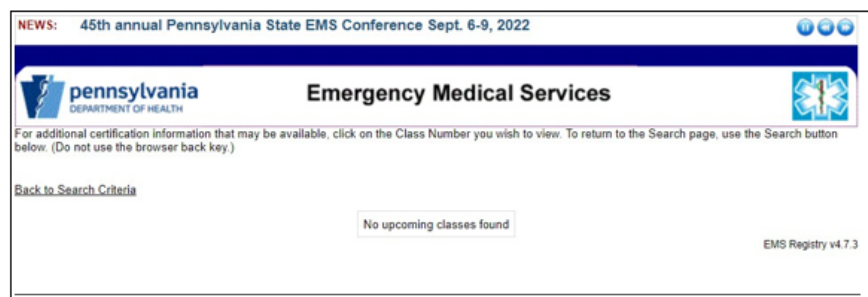
EMS Tool Kit		Applicability:
Focus Group:	Training and Certification	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Accessibility	
Type:	Recommendations	

Figure 2 – Screen Capture – Website Search Functionality



Additionally, the EMS registry that allows users to search through all available certification classes will only return information with the input of specific criteria. In the absence of available classes within the county(ies) searched, no related or suggested nearby classes are provided to the user.

Figure 3 – Screen Capture – Certification Class Search





EMS Tool Kit		Applicability:
Focus Group:	Training and Certification	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Accessibility	
Type:	Recommendations	

Recommendations:

PA Department of Health

- Revise the set of [Emergency Medical Services \(EMS\) \(pa.gov\)](http://pa.gov) website pages related to emergency medical services certification with a more user-friendly and graphical user interface by the responsible entity.
- Increase web functionality on the EMS Registry page for geographic proximity when no direct search results are found.
- Include an aggregation engine on the certification webpage for interested individuals to search their immediate geographic area or region for emergency medical service providers, as well as links to Department of Health approved training facilities.
- Provide for a link, banner, pop-up window, or other mechanism initiated from the landing page of the Department of Health site linked to the above noted aggregation page. Links should also be included on other state, county, and municipal government websites with public-safety related information, i.e. – PEMA.



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TOOL #2

TRAINING AND CERTIFICATION: TRAINING AVAILABILITY



EMS Tool Kit		Applicability:
Focus Group:	Training and Certification	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Training Availability	R-S-U/V-P
Type:	Recommendations	

Introduction:

Pursuing a volunteer or career path in emergency medical services requires individuals to affiliate with a state accredited training facility or emergency medical services agency.

Discussion:

Ease of locating available training classes is discussed in the accessibility toolkit. However, prospective trainees and current emergency medical service agencies searching for scheduled classes must successfully complete multiple searches in their county and adjacent counties and collect the class information independently. Once identified, prospective trainees and/or emergency medical services agencies must sort the classes in start date order.

Across the Commonwealth of Pennsylvania, paramedic programs are offered at only eighteen locations. Seven of the locations are concentrated in the southeast region of the state while another seven are concentrated in the southwest region. Of the remaining locations, one paramedic program is based in the northeast while the central region of the state is served by the final three locations. Due to the length of the program, averaging one year up to eighteen months, locations may only host one offering annually, potentially removing the opportunity for a significant period based upon the prospective student's location.

Recommendations:

Counties, Municipalities and Agencies

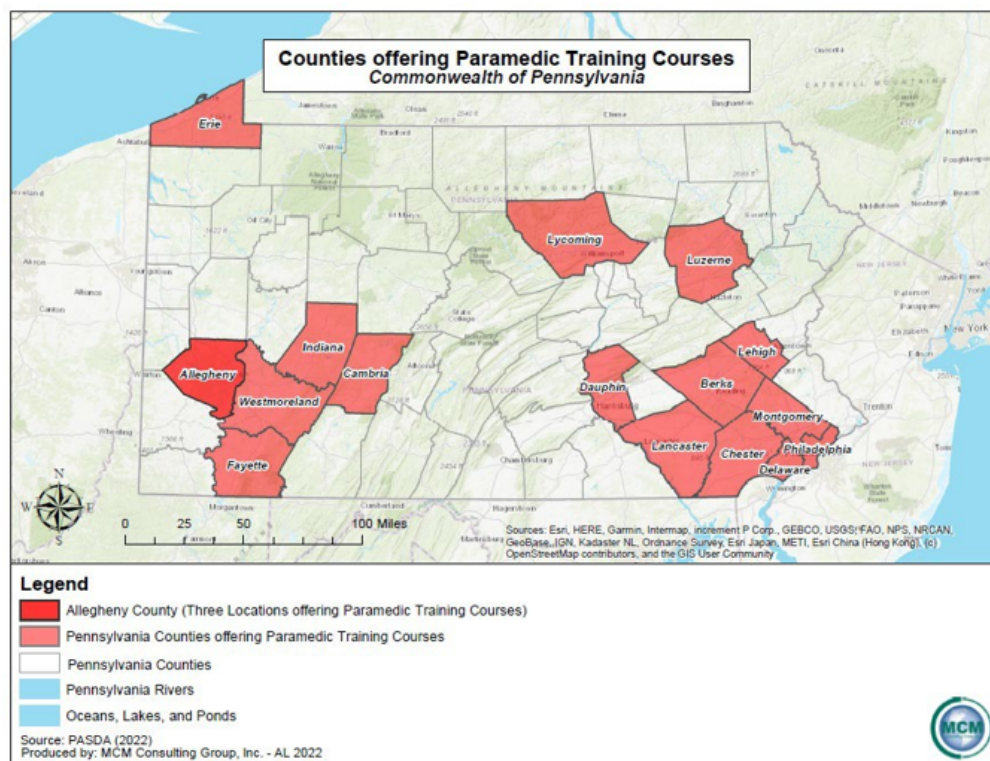
- Encourage the PA Department of Health to develop a diversification plan to incorporate additional paramedic program training locations throughout the Commonwealth.
 - Develop partnerships with community colleges, hospitals, and health networks to increase the available locations of program offerings.
 - Maintain partnerships with training facilities by incentivizing the organizations through direct and indirect funding.
- Encourage the PA Department of Health to consider the recommendations presented below.



EMS Tool Kit		Applicability:
Focus Group:	Training and Certification	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Training Availability	
Type:	Recommendations	

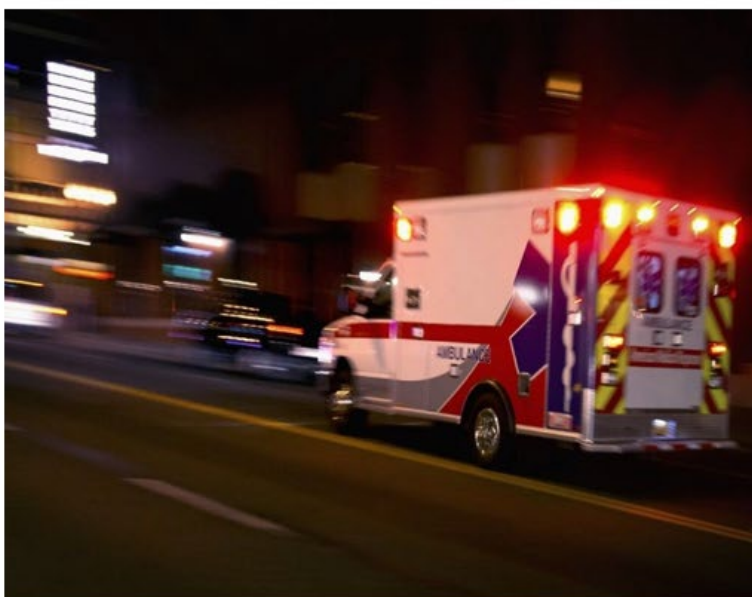
PA Department of Health

- Increase oversight of the training facilities course offerings, coordinating program starting dates that provide for choice in location for students.
- Include a graphical representation of the state with links identifying paramedic program training facilities as a component of the Department of Health website.
- Maintain the EMS Registry page with current and future program offerings.





Pennsylvania EMS Crisis



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Toolkit and Recommendations

TOOL #3

RECRUITMENT AND RETENTION: HIGH SCHOOL EMS PROGRAMS



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer R-S-U/V-P
Area:	Recruitment - High School EMS Programs	
Type:	Model Program/Best Practices	

Introduction

The results of the survey of EMS providers in the five study counties indicated that it is getting harder to find people that want to volunteer or work in EMS. In today's world there are myriad activities vying for peoples' attention and time. Getting youth involved in EMS is a good way to take advantage of an energetic demographic that may be overlooked and foster in them a lifelong commitment to giving back and helping their communities.

Discussion

Teenagers often bring a fresh perspective, passion, and energy to organizations. They tend to be more technologically savvy and more open to new ideas, meaning they can help drive positive change and create new opportunities for improvement. One way to encourage youth to participate in EMS is to offer EMT training as high school or college-level credit courses.

Best Practice: Las Vegas area high school programs

*Like other EMS agencies, private ambulance services in the Las Vegas area have faced ongoing recruiting challenges for EMTs and paramedics. Enrollment in EMT education programs in their area has been down since the pandemic, meaning fewer potential paramedic candidates later on. By supporting the high school programs, Guardian Elite and Community Ambulance hoped to ensure a stream of new EMTs who would be interested in starting their careers there, and who had the potential to become paramedics. Community Ambulance and Guardian Elite provide ride-alongs and internship opportunities for high school EMS students. Scheller also sits on Veterans Tribute's advisory board for technical education. The EMS curriculum begins in 9th grade with a foundation of public safety course, followed by health sciences, anatomy and physiology courses for sophomores and juniors. Seniors can then take the 180-day EMT course, including clinical rotations with local EMS agencies. The school also brings in EMS, law enforcement and medical professionals from the community as speakers. The EMS class uses a mock ambulance, stretchers, CPR mannequins and other medical equipment for hands-on skills. There's also a mock 911 call center for emergency dispatch students, a forensics lab and a cybersecurity lab.**

*National Association of Emergency Medical Technicians "Innovative Recruitment Strategies for EMS Agencies". For the full article: https://naemt.org/docs/default-source/2017-publication-docs/recruitment-strategies-02-04-2022-1.pdf?sfvrsn=2bade893_2



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer
Area:	Recruitment - High School EMS Programs	R-S-U/V-P
Type:	Model Program/Best Practices	

Recommendations

Agencies:

- Determine if the local high schools/Vo-Tech schools offer EMT training.
- Determine if the local community colleges/colleges offer EMT or Paramedic training programs.
- If training is offered, explore working with the educational facility to support the program as much as possible with the goal of recruiting the students to your agency once they successfully complete the program.
 - Provide education materials
 - Offer ride-alongs
 - Provide volunteer instructors
 - Offer signing bonuses after graduation
- If training is not offered, work with high schools/Vo-Tech school to explore the feasibility of developing local programs.

County Considerations

- Assist EMS agencies in outreach to schools if needed.
- Provide assistance on integrating EMS training into curriculums if needed.



January 2023

Toolkit and Recommendations

TOOL #4

RECRUITMENT AND RETENTION: FINANCIAL INCENTIVES



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer
Area:	Recruitment and Retention - Financial Incentives	R-S-U/V-P
Type:	Model Program/Best Practices	

Introduction

One method of recruiting and retaining EMS volunteers and paid staff is to offer cash incentives or free training.

Discussion

Washington County, Maryland has instituted a county-funded program that provides cash incentives for every call a volunteer responds to, above the initial 40 calls per year that is required for the county's length of service awards program (LOSAP). The amount of the incentive would depend on the volunteer's fire or EMS certification level and officer status. The intent is not only to help volunteers who go on calls, but also to get them to increase their training levels and step up for leadership positions. The incentives are:

- An Emergency Support Services (air/rehab unit) or fire police volunteer would get \$4 per call.
- A Firefighter I or emergency medical technician (EMT) would get \$5 per call.
- A Firefighter I who also is either an emergency medical responder (EMR) or EMT would get \$6 per call.
- A Firefighter II would get \$7 per call.
- A Firefighter II who also is an EMR or EMT would get \$8 per call.
- A captain or lieutenant would get an additional \$1 per call.
- A chief officer (such as a chief, deputy chief or assistant chief) would get an additional \$2 per call.
- A paramedic would get an additional \$1 per call.

In addition to the per call incentives, the county also provides:

- Fire and EMS volunteer responders are eligible for a \$125 quarterly stipend if they complete 18 duty shifts in a quarter, with a \$500 annual maximum.
- Through the Length of Service Awards Program (LOSAP), an income-tax break is available to fire and EMS volunteers if they meet a minimum amount of volunteer hours over a three-year period.
- Through LOSAP, retirement benefits are also available.

There are many similar programs in place across the country.



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Recruitment and Retention - Financial Incentives	
Type:	Model Program/Best Practices	

There are several examples of municipalities and EMS agencies in Pennsylvania that offer free training and certification, sometimes in turn for commitments of service for set time periods. Manor Township in Armstrong County for example, will pay the total cost (approximately \$12,000.00) for paramedic training and certification in turn for a three-year commitment to the municipal EMS system.

County and Municipal Considerations

- Facilitate discussions with EMS agencies to determine if a per-call incentive program would be feasible in terms of record keeping and funding.
- Consider funding a program with county funds.
- Petition Congress to provide federal tax exemptions for any state or local benefits that volunteers receive.
- Consider paying for EMS training and certification for new hires in return for a service commitment.



Pennsylvania EMS Crisis



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Toolkit and Recommendations

TOOL #5

RECRUITMENT AND RETENTION: LIVE-IN PROGRAMS



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Live-in Programs	R-S-U/V
Type:	Recommendations	

Introduction:

Live-in programs for college students, trained in emergency medicine (i.e., EMR, EMT, etc.) provide a response agency with increased, in-house, trained personnel.

Discussion:

Live-in programs are opportunities available to college students or other interested individuals. In exchange for being available for responses a set number of hours per week, attending training, and performing other tasks as needed, live-ins are provided with free housing.

Benefits:

- Provides larger staffing pool at low- or no-cost.
- Incentivizes students to participate, by saving on housing costs.
- Provides staff on-station during over-night hours, which decreases response times.
- Return on investment for agencies offering live-in programs through completion of daily and weekly tasks by the live-ins.

Recommendations:

Agencies:

- Consider offering live-in programs.
- Develop policies and procedures for the live-in program.
- EMS agencies (that have available space) should work with a college or university in their primary response area should work with the higher education system to advertise that they can provide housing for students with the understanding that they provide a certain number of hours per week/day running on emergency calls and completing duties at the station.
- Live-in programs can also be offered to non-college students if the agencies desire.

Loyalsock Fire Department, Williamsport, has a working relationship with Pennsylvania College of Technology.

Alpha Volunteer Fire Company, State College, provides this opportunity to students at Penn State University Main Campus.

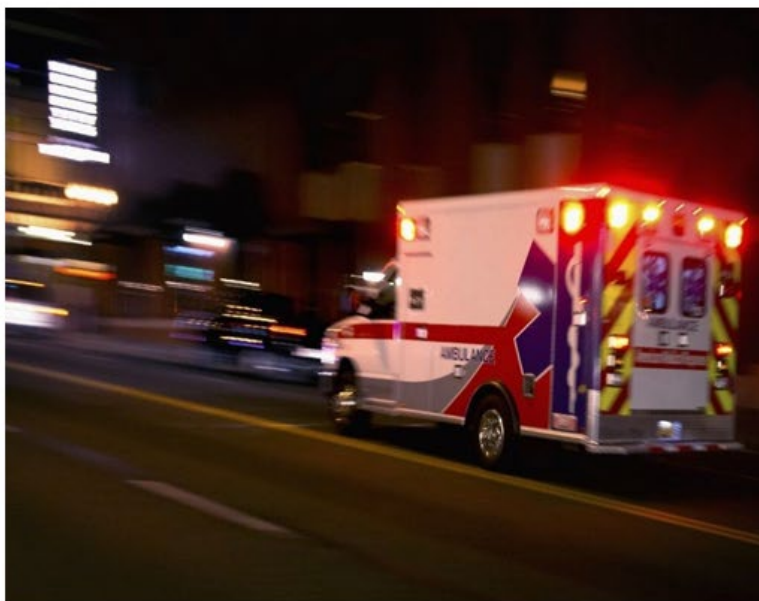


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TOOL #6

RECRUITMENT AND RETENTION: REFERENCE ARTICLES



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer R-S-U/V-P
Area:	Recruitment and Retention	
Type:	Reference Articles	

Introduction

There are Numerous articles and white papers pertaining to EMS recruitment and retention that can be found on the internet. There is too much content in the articles/papers to include full copies in this report. Links to some of the articles/papers of interest are listed below.

- <https://www.firerescue1.com/recruitment/articles/do-something-different-why-its-time-to-question-everything-about-recruitment-vEnmflrPWecqn4ea/>
- <https://www.jems.com/special-topics/jems-at-fdic/jems-con-2022-preview-modern-ems-recruitment-and-retention/>
- <https://www.ruralhealthinfo.org/rural-monitor/ems-recruitment-retention/>
- <https://amuedge.com/why-ems-recruitment-and-retention-remain-ongoing-problems>
- <https://www.jems.com/administration-and-leadership/recruitment-and-retention-a-perennial-problem-in-ems/>
- <https://pubmed.ncbi.nlm.nih.gov/16252678/>
- <https://www.providentins.com/reshifting-focus-from-recruitment-to-retention-in-ems/>
- <https://www.health.state.mn.us/facilities/ruralhealth/emskit/recruit.html>
- <https://www.vdh.virginia.gov/emergency-medical-services/chatr/recruitment-retention/>
- <https://emsleadershipacademy.com/why-retention-is-the-key-to-recruitment/>
- <https://www.lexipol.com/resources/blog/pandemic-woes-funding-recruitment-and-retention-efforts-for-rural-ems-agencies/>
- www.naemt.org/docs/default-source/member-resources-documents/Emergency_Medical_Services_Recruitment_and_Retention_Manual.pdf?sfvrsn=d2def07c_4
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EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer R-S-U/V-P
Area:	Recruitment and Retention	
Type:	Reference Articles	

- https://www.researchgate.net/publication/365933459_What_innovations_help_with_the_recruitment_and_retention_of_ambulance_staff_a_rapid_evidence_summary
- <https://www.linkedin.com/pulse/ems-recruitment-retention-ferris-wheel-how-break-abbas-ms-nrp/>
- <https://texasemsschool.com/texas-ems-scholarship-program/>
- <https://www.pulsara.com/blog/ems-trend-report-2022-proven-recruitment-and-retention-strategies>
- <https://www.linkedin.com/pulse/5-tips-reduce-turnover-ems-agency-scott-moore/>



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TOOL #7

RECRUITMENT AND RETENTION: RETENTION INCENTIVES



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer R-S-U / P
Area:	Recruitment and Retention	
Type:	Retention Incentives	

Introduction:

Staffing shortages are one of the main reasons for the crisis that EMS agencies find themselves in today. Training new EMS staff is costly in terms of both time and money. This makes retaining current staffing a high priority.

Discussion:

Turnover continues to be a big problem for EMS agencies. A study in 2021 by the American Ambulance Association noted that the turnover rate for EMTs and paramedics was 20-30% per year. A 25% turnover rate per year equates to 100% staff turnover every four years. There are many reasons that turnover in EMS is high, including long shifts, low pay, less than optimal working conditions, high stress, limited staff engagement, poor management, and limited career advancement potential. When openings exist, other staff must fill the gaps, adding additional strain and stress. Providing incentives is one tool to help agencies retain the staff that they have. Incentives can be as simple as saying “thank-you” or providing clothing or other tangible items, to more larger incentives such as regular pay increases, end of year bonuses, etc.

Recommendations:

EMS agencies should consider incentives such as:

- Foster a supportive work environment, one where job performance and emotional, physical, and mental well-being of staff members are valued. Employees who feel valued and supported perform better at work and go beyond their required duties.
 - Provide positive feedback.
 - Seek staff input on corporate issues.
 - Facilitate opportunities for learning.
 - Develop a strong workplace culture.
 - Utilize a mentoring program for new employees.
 - Ask for feedback.
 - Provide strong leadership.
- Offer step or regular pay increases.
- Provide access to employee assistance programs and [stress debriefing](#) services.
- Communicate often with staff to keep them up to date on agency issues.
- Provide uniforms or uniform allowances.
- [Allow for](#) pet therapy with service dogs at the stations.
- Offer recognition programs.
- Provide free continuing education.



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer
Area:	Recruitment and Retention	R-S-U / P
Type:	Retention Incentives	

- Develop a meaningful career ladder.
- Offer tuition assistance.
- Hire the right people. Hiring staff that do not appear to have the right demeanor and aptitude for the job may solve the short-term staffing need by providing warm bodies, however it ends up being counterproductive and costing the organization more money overall.

County Considerations:

- Offer to assist EMS agencies with consultation from county human resources staff members.
- Support EMS agencies as much as possible with development of retention tools if needed.
- Provide financial support for retention programs to the extent possible.

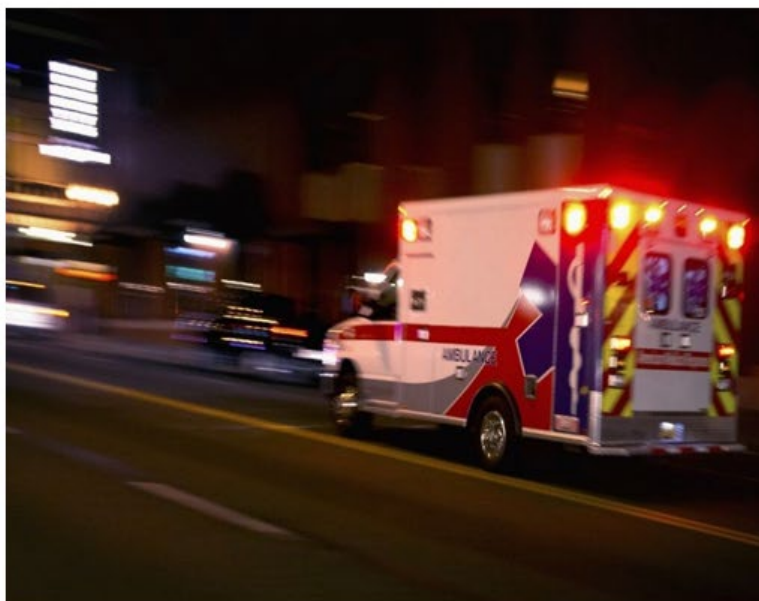


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TOOL #8

RECRUITMENT AND RETENTION: RECRUITING ON SOCIAL MEDIA



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban - P: Paid / V: Volunteer
Area:	Recruitment - Recruiting on <u>Social Media</u>	R-S-U/V-P
Type:	Model Program/Best Practices	

Introduction

Social media is ubiquitous in today's society and is a great pathway for getting information out to the general public. As such, it can be a great tool for recruiting new EMS personnel. Utilizing the correct social media platforms is important in reaching the desired audience.

Discussion

It is recommended that social media be utilized as a recruitment tool for recruitment for EMS agencies. However, agencies must be aware that all social media sites are not the same, and they appeal to potential staff differently. During the five-county study, it was noted that, of the EMS agencies that have a presence on social media, the majority utilize agency web pages and Facebook. However, the younger demographic is leaning away from Facebook and spending more time on other platforms. Instagram, TikTok, Twitter, YouTube and other similar platforms are appealing to teenage and early-twenties groups, while Facebook, LinkedIn and other similar apps are utilized more by people in their 30's and older. Recruitment on social media should be tailored toward the demographic that is trying to be reached.

Recommendations

- Agencies should first decide the demographic that they want to appeal to and use the appropriate social media platforms. If unsure, it is recommended to utilize as many social media platforms as possible.
- A recruitment video should be developed, along with short reels that can be shown on social media platforms (Facebook, TikTok, etc.) that employ them. Partner with community television services, high school or college media programs, or other local media services to develop the videos at little or no cost.
 - Sample recruitment videos:
 - https://www.youtube.com/watch?v=bii_UcT8WCk
 - <https://www.youtube.com/watch?v=oyTk8LbbWFc>
 - <https://www.youtube.com/watch?v=5SP77-Kys00>
 - <https://www.facebook.com/watch/?ref=external&v=850480665415201>
 - <https://www.facebook.com/watch/?v=124687166169797>
 - <https://www.youtube.com/watch?v=rfsh-VOb3BI>
- An agency website should be developed, if it does not already exist, and recruitment should be highlighted on the home page.
- Benefits of membership/employment should be highlighted, including service to the community.
- Job openings at paid agencies should be listed on social media sites.]



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention	R: Rural / S: Suburban / U: Urban - P: Paid / V: Volunteer
Area:	Recruitment - Recruiting on social media	R-S-U/V-P
Type:	Model Program/Best Practices	

County Considerations

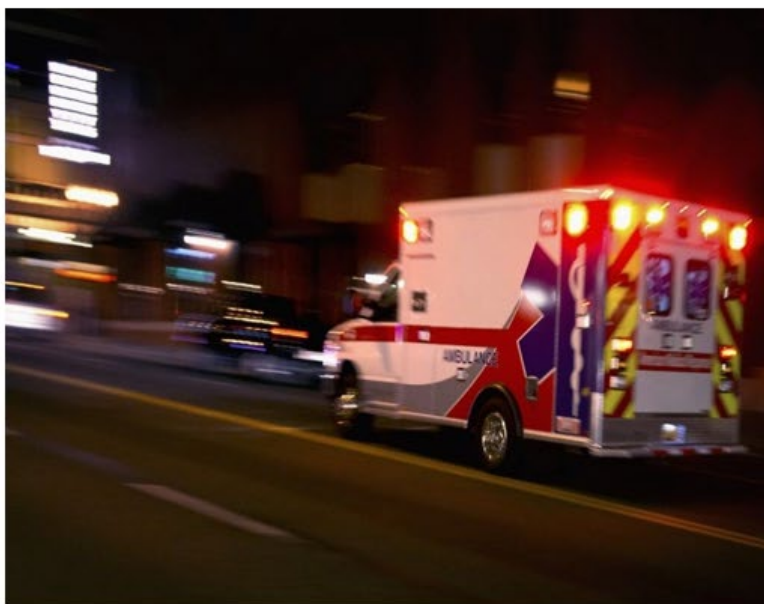
- Support EMS agencies as appropriate in the development of recruitment media.
- Provide web-hosting services if capable.
- Allow recruitment videos or other appropriate media to be placed on county web sites.
- Encourage community television stations or other local media outlets to provide services at little or no cost to EMS agencies.



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TOOL #9

RECRUITMENT AND RETENTION/ FINANCIAL STABILITY: TAX CREDITS AND FINANCIAL INCENTIVES



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention/Financial Stability	R: Rural / S: Suburban/ U: Urban P: Paid / V: Volunteer
Area:	Tax Credits and Financial Incentives	R-S-U/V
Type:	Recommendations	

Introduction:

The Borough and Township Codes of Pennsylvania state that municipalities shall provide for emergency medical services for the citizens within their municipality.

The Borough Code - 8 Pa.C.S. § 1202, Specific Powers.

The powers of the borough shall be vested in the council. In the exercise of any specific powers involving the enactment of an ordinance or the making of any regulation, restriction or prohibition, the borough may provide for enforcement and penalties for violations. The specific powers of the borough shall include the following:

(56) To ensure that fire and emergency medical services are provided within the borough by the means and to the extent determined by the borough, including the appropriate financial and administrative assistance for these services.

Second Class Township Code - 53 P.S. § 66553, Emergency Services.

(a) The township shall be responsible for ensuring that fire and emergency medical services are provided within the township by the means and to the extent determined by the township, including the appropriate financial and administrative assistance for these services.

First Class Township Code - 53 P.S. § 56579.52, Emergency Services.

(a) The township shall be responsible for ensuring that fire and emergency medical services are provided within the township by the means and to the extent determined by the township, including the appropriate financial and administrative assistance for these services.

Third Class Cities - 11 Pa. C.S. § 12446

a) Provision of emergency services -A city shall be responsible for ensuring that fire and emergency medical services are provided within the city by the means and to the extent determined by the city, including the appropriate financial and administrative assistance for these services.

Emergency medical services continue to struggle with operations and finances. Elected officials of municipalities have certain powers to potentially assist emergency medical services. The following are practices and recommendations that could be implemented to help ensure financial stability for emergency medical services that service the municipality.



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention/Financial Stability	R: Rural / S: Suburban/ U: Urban P: Paid / V: Volunteer
Area:	Tax Credits and Financial Incentives	R-S-U/V
Type:	Recommendations	

Discussion:

As Outlined in 35 Pa.C.S. §§ 79A01 – 79A33, municipalities may offer a tax credit to volunteers of fire departments and nonprofit emergency medical services agencies. This tax credit was enacted to acknowledge the value and the absence of any public cost for volunteer fire protection and nonprofit emergency medical services provided by active volunteers and to encourage individuals to volunteer or for former volunteers to consider rejoining as active volunteers in a volunteer fire company or nonprofit emergency medical services agency. The tax credit may be made by a municipality, which includes counties, boroughs, townships and other entities. It does not include school districts. The credit cannot exceed the tax liability.

Requirements:

- Municipalities must levy an earned income tax.
- The municipality chooses the amount of the tax credit.
- The municipality may choose to apply the tax credit against real property tax.
- The tax credit may not exceed the amount of the individual's tax liability.

Cumberland County has instituted a tax credit of up to \$250.00 on county real estate taxes for volunteer fire fighters and volunteer EMS providers.

See: www.cumberlandcountypa.gov/DocumentCenter/View/41466/Cumberland-County-Volunteer-EMS-and-Firefighter-Tax-Credit-Ordinance-2022-2

The Borough of Gettysburg has adopted a tax credit program for volunteer members of the local fire department. Each eligible volunteer is eligible to receive a tax credit of 100% of the earned income tax levied by the Borough, up to \$1,000.00, and also a tax credit of 100% of the real property tax levied by the Borough on qualified real property.

See:

www.gettysburgpa.gov/sites/g/files/vyhlf3156/f/uploads/fire_protection_volunteer_tax_credit_ordinance_draft.pdf

Act 222 of 2004 amends the Local Tax Enabling Act, Act 511 of 1965, to permit municipalities and school districts (except the Pittsburgh School District) to impose a combined Emergency and Municipal Services Tax (EMS tax) of up to \$52 a year beginning on and after January 1, 2005. The EMS tax replaces the occupational privilege tax. The total EMS tax paid by any individual in a calendar year is limited to \$52, regardless of the number of political subdivisions in which an individual works during the year.



EMS Tool Kit		Applicability:
Focus Group:	Recruitment and Retention/Financial Stability	R: Rural / S: Suburban/ U: Urban P: Paid / V: Volunteer
Area:	Tax Credits and Financial Incentives	R-S-U/V
Type:	Recommendations	

Municipalities must use funds from an EMS tax for police, fire or emergency services; road construction or maintenance; or for the reduction of property taxes.

See: www.legis.state.pa.us/WU01/LI/BI/ALL/2003/0/HB0197.HTM

Title 8, Pa.C.S § 1302 to levy and collect annually a tax not exceeding 30 mills for general borough purposes including support for EMS and fire department operations. The support for fire departments can be up to three mills or higher if approved by referendum. The support for EMS agencies can only go up to two mills if approved by referendum.

See:

www.legis.state.pa.us/cfdocs/legis/LI/consCheck.cfm?txtType=HTM&ttl=08&div=0&chpt=13&sctn=2&subctn=0

Donations, Subscriptions and Fundraisers

Donations, subscriptions and fundraisers can also be used to assist a municipality with financial stability. These methods should be used to merely augment the financial stability process to increase revenue and not be used as a sole purpose to enhance this situation. These methods are not a sustainable or reliable recurring option but could be used to assist with various action items of an EMS.

Recommendations:

Municipalities and Counties

- Municipalities and Counties could assist EMS agencies with grant funding research and application. See the Financial Stability - Grants tool kit more detailed information.
- Municipalities and Counties can consider adopting the tax programs and credit incentives outlined above.
- Municipalities and Counties could petition the General Assembly for an increase in the millage that is allowed to be allocated for EMS support under Title 8, Pa.C.S § 1302.
- Municipalities and Counties could provide clerical staff for the printing, mailing and processing of subscription services or fund drives.
- Municipalities and Counties could develop and market a donation drive from public and private partnerships to generate donation funding or other resources for EMS agencies.



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Toolkit and Recommendations

TOOL #10

FINANCIAL STABILITY: BUSINESS AND ADMINISTRATION



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Business and Administration	R-S-U/V-P
Type:	Sample Forms - Recommendations	

Business and Administration

Introduction:

Financial stability is vital to the success of any organization, whether it be for-profit, not-for-profit, or non-profit. Service organizations, especially volunteer service organizations, are not often considered in terms of a business model, and as such, the importance of financial stability can be overlooked. Effective business administration is necessary for the successful operation of EMS agencies, both volunteer and paid services.

Discussion:

To operate successfully, EMS agencies need an organized business plan, personnel experienced in business administration and management, appropriate templates for budgeting, an accounts payable/accounts receivable process, and a system for billing. Many agencies, especially small rural agencies do not have members with business administration or finance experience. Additionally, many services are operating without an organized business plan, a short-, medium- and long-term plan for anticipated income and forecasted expenses, or an effective system for billing. A lack of proper documentation on patient care, and a lack of training in medical coding create inefficiencies in billing which negatively impact income. Ineffective accounts payable and expense forecasting can further tax the limited revenue.

Recommendations:

Agencies:

- Recruit/hire an individual with business management, accounts payable/receivable, or financial management experience.
- Request pro-bono assistance from an accountant.
- Use a budgeting form template, software or cloud-based program.
- Forecast and prioritize capital expenditures, i.e., vehicles, and equipment.
- Research funding sources.
 - Insurance reimbursement – Medicare, Medicaid, insurance companies
 - Petition the governing or regulating agencies for increased Medicare/Medicaid reimbursement rates.
 - Petition the governing or regulating agencies for reasonable reimbursement for treatment without transport.



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Business and Administration	R-S-U/V-P
Type:	Sample Forms - Recommendations	

- Request insurance agencies to directly reimburse EMS services as opposed to the insured.
- Cost recovery for response to motor vehicle accidents, structure fires, etc. where insurance companies will be involved.
- Grants
 - Recruit volunteers or hire staff with grant writing experience.
 - Utilize municipal or county financial staff or grant writers for assistance.
 - Refer to the grants toolkit for available grant opportunities.
- Charitable contributions
 - Recruit volunteers to research and reach out to organizations within your community for financial, or in-kind donations
- Crowd funding sites
- Membership programs
 - Agency administrators can organize and lead membership programs.
- Donations/Fundraising events
 - Recruit volunteers with event planning experience to organize fundraising events within your community.

Municipalities:

- Work with EMS agencies on community outreach for recruitment of volunteers, pro-bono or in-kind services, sharing of budgeting forms or programs.
- Work with county government to request and support changes in legislation to increase reimbursement rates from Medicare and Medicaid programs.
- Consider tax programs that would benefit EMS agencies.
- Support EMS agencies with municipal finance personnel or grant writers.

Tools:

- Budget model template – attachment
- HRSA Rural Ambulance Service Budget – attachment



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TOOL #11

FINANCIAL STABILITY: BILLING



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Billing	
Type:	Recommendations	

Introduction:

The primary source of income for emergency service agencies is billing for use of services. Third party billing is the most used method of billing; however, third party billing is also an expense for services. There are a variety of vendors who provide billing services to EMS agencies at a variety of price points. It is important to the financial health of any agency that the return on investment exceeds the cost of the service.

Recommendations:

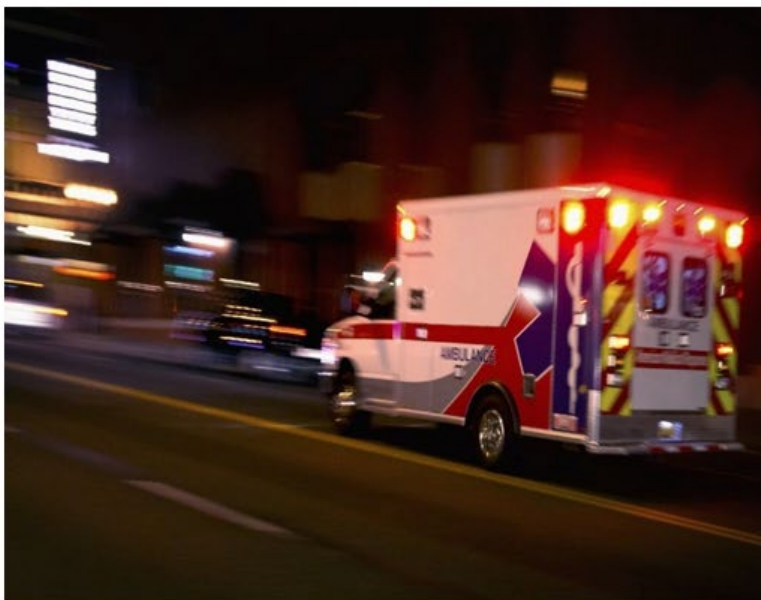
- Research vendors and software packages to determine the highest return on investment.
- Leverage a public purchase option such as COSTARS which could provide a list of vendors at a controlled or more reasonable price point.
- Leverage community outreach to partner with agencies to share third party billing support.
- Recruit volunteers who have insurance and/or medical billing experience.

County Considerations:

- Support municipalities and/or EMS agencies by providing information on access to third party billing vendors.
- Support outreach to community partners who have insurance and/or medical billing experience.
- Provide billing services at reduced or no cost.



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Toolkit and Recommendations

TOOL #12

FINANCIAL STABILITY: BUDGET



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Budget	R-S-U/V-P
Type:	Sample Forms	

Introduction:

Financial stability is vital to the success of any organization, whether it be for-profit, not-for-profit, or non-profit. Service organizations, especially volunteer service organizations, are not often considered in terms of a business model, and as such, the importance of financial stability can be overlooked.

Discussion:

To operate successfully, EMS agencies need an organized business plan, to include a business plan, personnel experienced in business administration and management, appropriate templates for budgeting, an accounts payable/accounts receivable process, and a system for billing.

- Issue to consider – Private industry can increase wages because they can increase prices. Without county or municipal support, EMS agencies are limited to Medicare/Medicaid/insurance reimbursement rates which are fixed rates.

The guidance of a business or financial representative who can lead the organization in budget forecasting, positive alignment of income versus expense, and account maintenance is recommended. Many organizations do not have membership with business or financial management backgrounds, effective budget processes, or an efficient and effective accounting system.

Recommendations:

- Recruit/hire an individual with business management, accounts payable/receivable, or financial management experience.
- Request pro-bono assistance from an accountant.
- Use one of the budgeting form templates, software or cloud-based programs
- Forecast and prioritize capital expenditures, i.e., vehicles, and equipment.
- Research funding sources.
 - Insurance reimbursement – Medicare, Medicaid, insurance companies
 - Cost recovery for response to motor vehicle accidents, structure fires, etc. where insurance companies will be involved.
 - Grants
 - Collaboration with other agencies
 - Financial and programmatic capacity
 - Leadership
 - Measurable results
 - Charitable contributions



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Budget	R-S-U/V-P
Type:	Sample Forms	

- Crowd funding
- Membership programs

County Considerations

- Counties could provide guidance to municipalities on supporting EMS agency financial functions with municipal or county financial personnel.
- Counties could provide a database of funding opportunities for municipalities and EMS agencies, and assistance with grant writing.
- Counties could share budgeting programs with municipalities and EMS agencies.

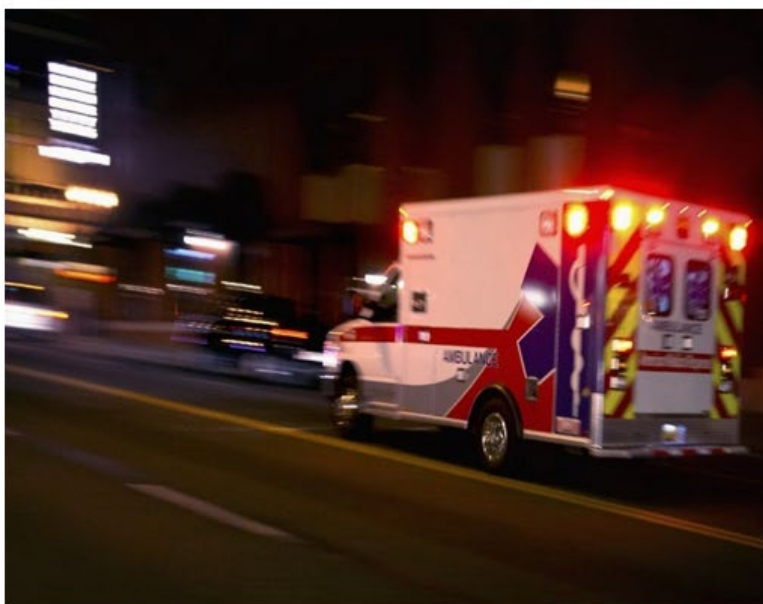


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TOOL #13

FINANCIAL STABILITY: BUSINESS AND ADMINISTRATION - BILLING



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Business and Administration - Billing	
Type:	Recommendations	

Financial Stability – Business and Administration

Billing

Introduction:

Billing is the primary source of income for EMS agencies. The absence of effective billing practices, a lack of patient care information for medical coding, and insufficient reimbursement rates are all contributing to the financial issues which many EMS agencies are currently facing.

Discussion:

Both billing practices and billing issues that EMS agencies encounter are multifaceted. Many agencies do not have administrative personnel with medical coding or medical billing experience. This can lead to insurance companies, Medicare, and Medicaid not processing reimbursements, or providing full or accurate reimbursements due to a lack of information. Contributing to this could be a lack of thorough patient care reporting submitted for billing. Additionally, billing software programs are an expense for EMS agencies and there is currently not a bulk purchase option for agencies across the Commonwealth being supported by the Department of Health or PEMA. Finally, reimbursement rates governed by the insurance industry, Medicare and Medicaid are insufficient to cover costs of operation and have not been increased over time in order to keep up with inflation and COL rates. During the course of this study one EMS agency noted that, on average, they lose \$120.00 per call due to insufficient reimbursement rates.

Recommendations:

Agencies

- Recruit personnel with medical billing experience.
- Use a third-party service to ensure more accurate billing – conversely, this is an expense to the agency.
- Ensure that patient care reports are completed by response staff to increase accuracy of coding and probability of reimbursement.
- Use billing software – potentially look at a bulk license purchase with other area agencies.
- Partner with local medical practices for billing services offered as an in-kind donation.



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Business and Administration - Billing	R-S-U/V-P
Type:	Recommendations	

Municipalities

- Support agencies with financial personnel from the municipality to provide billing services.
- Support agencies with assistance with third-party billing expenses.
- Petition the governing or regulating agencies for increased Medicare/Medicaid reimbursement rates.
- Petition the governing or regulating agencies for reasonable reimbursement for treatment without transport.
- Request insurance agencies to directly reimburse EMS services as opposed to the insured.

County Considerations

- Petition the governing or regulating agencies for increased Medicare/Medicaid reimbursement rates.
- Petition the governing or regulating agencies for reasonable reimbursement for treatment without transport.
- Request insurance agencies to directly reimburse EMS services as opposed to the insured.
- Support the municipalities and agencies in your county by assisting with coordination and negotiation of a group purchase of licensing for software, or third-party billing.
- Support agencies with financial personnel from the to provide billing services.
- Support agencies with assistance with third-party billing expenses.



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TOOL #14

FINANCIAL STABILITY: BUSINESS AND ADMINISTRATION - PERSONNEL



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Business and Administration - Personnel	R-S-U/V-P
Type:	Recommendations	

Financial Stability – Business and Administration

Personnel

Introduction:

The effective financial management and administration of EMS agencies is vital to the success of the agency, and in part, its ability to serve the citizens of its community.

Discussion:

There is a nationwide crisis in EMS, fueled primarily by a decrease in volunteerism and interest in careers in paramedicine. Due to a lack of providers, the primary focus of EMS agencies is to recruit, train and retain EMTs and paramedics. However, both partially staffed, and fully staffed agencies alike need to operate under a business model including short-, medium-, and long-term financial plans, accounts payable/accounts receivable processes, and an effective system for billing. Strong administration and financial management will positively affect the success of any EMS agency.

The Pennsylvania Bureau of EMS has advised that they will be offering classes on business operations, budgeting, and grant writing.

See: <https://www.health.pa.gov/topics/EMS/pages/ems.aspx>

Recommendations:

Agencies

- Recruit volunteers or hire staff with business or financial management experience.
- Create partnerships with your municipal or county government for financial management support.
- Share resources with other EMS agencies for financial management.
- Encourage management personnel to attend EMS service management training, or financial management training.
- Provide training in medical coding for more efficient billing practices.
- Ensure that responders are completing accurate patient care reports for medical coding.
- Partner with an educational institution to provide a course specific to emergency service administration and financial management.



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Business and Administration	R-S-U/V-P
Type:	Business and Administration - Personnel	

Municipalities

- Partner with EMS agencies to support financial management systems.
- Share budgeting tools and platforms with EMS agencies.
- Include EMS agency personnel in financial training programs offered to municipal staff.

County Considerations

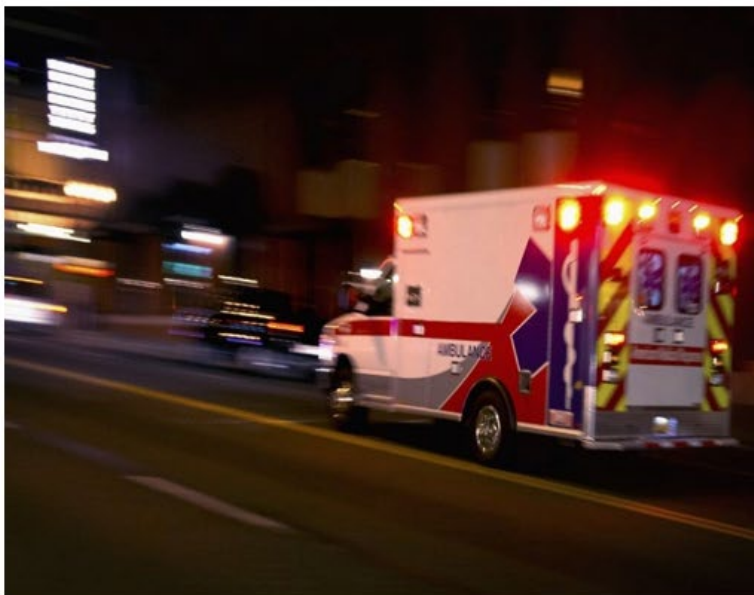
- Support EMS agency business and financial management with county financial staff.
- Include EMS agency personnel in financial training programs offered to county staff.
- Support recruitment of business and financial management volunteers or staff using county websites, social media, or other outreach efforts.



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TOOL #15

FINANCIAL STABILITY: GRANTS



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Grants	R-S-U/V-P
Type:	Recommendations	

Introduction:

Funding is the lifeline of emergency medical services (EMS) which ensures efficient and effective response to medical emergencies and enhance overall public safety. EMS agencies rely on various funding streams to acquire the necessary annual revenue to conduct EMS activities. Grant funding is one way to augment the revenue of an EMS agency and can sometimes provide funds that would not be available through standard operations and billing.

Recommendations:

Agencies and municipalities should take advantage of any/all available grant programs. Grant funding is allocated in various, non-recurring and recurring programs. The following outline some of the programs that have been identified to date:

Pennsylvania grant opportunities:

- Pennsylvania Fire and EMS Grant Program
 - <https://www.osfc.pa.gov/GrantsandLoans/Volunteer%20Fire%20Company%20And%20Ambulance%20Grants/Pages/default.aspx>
- Emergency Medical Services Operation Fund (EMSOF)
 - Apply through the EMS council for your area

Federal grant opportunities:

- FEMA Assistance to Firefighters Grant (AFG)
 - <https://www.fema.gov/grants/preparedness/firefighters>
- Rural Emergency Medical Services Training Grant
 - <https://www.samhsa.gov/grants/grant-announcements/ti-22-001>
- Flex Program Fiscal Year 2022 EMS Supplement Funding Guidance and Supporting Materials
 - <https://www.ruralcenter.org/resource-library/flex-program-fiscal-year-2022-ems-supplement-funding-guidance-and-supporting>
- United States Department of Transportation Highway Safety Grant Programs
 - https://safety.fhwa.dot.gov/shsp/ems/connection/sources_of_ems_funding.html
- Federal Grants Aggregation Page
 - <https://Grants.gov>

Private Grants/Foundations:

- National Philanthropic Trust
 - <https://www.nptrust.org>



EMS Tool Kit		Applicability:
Focus Group:	Financial Stability	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Grants	
Type:	Recommendations	

County Considerations:

- Support municipalities and/or EMS agencies by allowing assistance from county grant writers (if available) for grant applications.
- Assist with grant research by municipalities and/or EMS agencies.

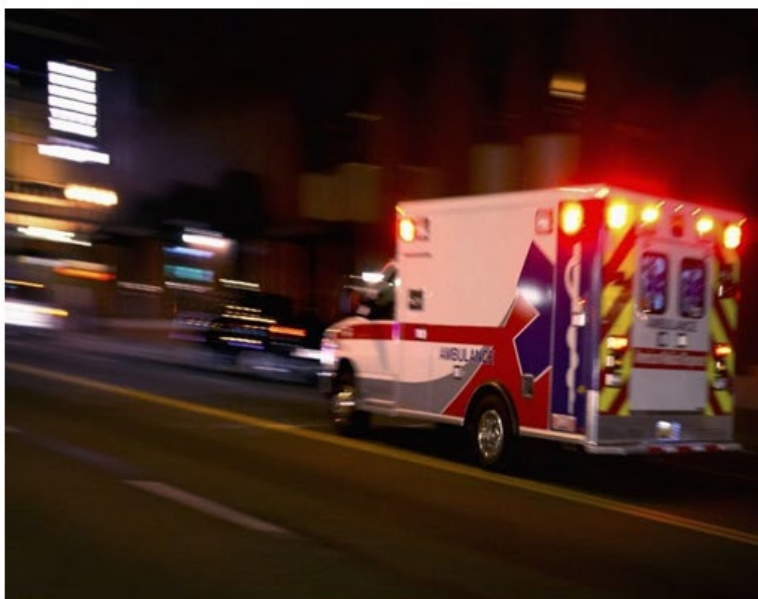


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TOOL #16

DELIVERY METHODS: COMMUNITY LIFELINE - PARAMEDICINE



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U: Urban P: Paid / V: Volunteer
Area:	Community Lifeline - Paramedicine	R-S-U/V-P
Type:	Recommendations	

Introduction:

Community paramedicine allows paramedics to function outside their traditional emergency response and transport roles to help facilitate more appropriate use of emergency care resources while enhancing access to primary care for medically underserved populations. Community Paramedics could provide more effective and efficient services, including preventative services, at a lower cost. Regular preventive services and on-site primary care services can decrease the need for ambulance dispatches.

Issues: Health and Safety codes would need to be addressed at the state level.

Discussion:

California Project concepts:

- Post discharge – avoid unnecessary EMS transports, emergency department (ED) visits, and hospital readmissions.
- Alternate Destination – relieve emergency room overcrowding, reduce costs, transport patients to care sites appropriate to meet their needs, and increase emergency services availability and options for the community.
- Frequent 911 – connect frequent 911 callers with services best able to address their needs, reduce costs, and reduce burdens on EDs from patients whose needs are better served by non-emergency aspects of health care or by the social system.
- Hospice – Provide hospice patients with the medical care and the support necessary to remain in their location of choice, rather than being transported to an emergency medical facility.
- Public Health Collaboration – Provide more efficient and effective healthcare of TB patients by partnering specially training Community Paramedics with public health department case workers.
- Behavioral Health – Provide behavioral health patients with the most effective, efficient, and timely care possible, ease ED overcrowding, reduce the number of patient transfers, and lower hospital and EMS system costs.
- Sobering Center – Provide patients with the most effective, efficient, and timely care possible, ease ED overcrowding, reduce the number of patient transfers, and lower hospital and EMS system costs.



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U: Urban P:Paid / V:Volunteer
Area:	Community Lifeline - Paramedics	R-S-U/V-P
Type:	Recommendations	

Rugby Community Paramedic Program (Five counties in North Dakota) offer the following services:

- Assessments
- Wound care
- Vital sign monitoring
- Medication administration
- Blood glucose monitoring
- Laboratory draws
- Medication reconciliation and compliance
- Patients enrolled in one of two programs:
 - Transitional care:
 - Primary care medical services administered in a patient's home.
 - Telephone follow-up calls made after each appointment.
 - The goal was to prevent hospital readmissions.
 - Chronic care:
 - Included evaluations, screenings, and care for patients with chronic diseases. EMS staff also made referrals for adjustments to the patient's home environment to better accommodate their medical situation.
 - Telephone follow-up calls were made after each appointment.

Additional services Community Paramedics could perform:

- Asthma management
- Diabetic testing/monitoring
- Immunizations
- INR testing/monitoring
- Telephone-based support to frequent 911 callers
- Training and education
- Well Baby checks

Some of the states that are supporting Community Paramedics:

- California **See attached document on California's Community Paramedicine Pilot Projects*
- Colorado
- Minnesota
- Maine
- Texas



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U: Urban P: Paid / V: Volunteer
Area:	Community Lifeline - Paramedics	R-S-U/V-P
Type:	Recommendations	

Summit County, Ohio, has a program where the sheriff's department visits homes of the elderly population. Not only do they identify issues such as "scam operations", they can also identify any medical issues.

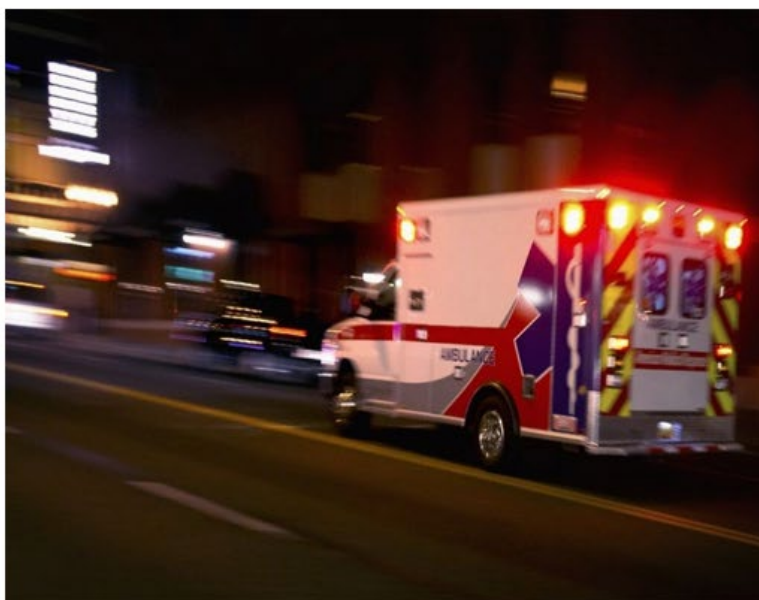
Recommendations:

Counties and Municipalities

- Assess the need for community paramedicine locally.
- Determine the cost-benefit of decreased transports versus implementing and maintaining paramedicine programs.



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TOOL #17

DELIVERY METHODS: COMMUNITY LIFELINE - PRIMARY CARE PROVIDERS AND SERVICES



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U: Urban P:Paid / V:Volunteer
Area:	Community Lifeline – Primary Care Providers and Services	R-S-U/V-P
Type:	Recommendations	

Introduction:

Many in the community may not have access to a primary care provider.

Discussion:

Patients that don't have access to a primary care provider (PCP) are more likely to have health issues and utilize or misuse/abuse emergency departments and EMS services. By initiating campaigns that encourage the use of, or providing access to, primary care providers can help prevent unnecessary calls for EMS services and improve the overall health of the community. This can not only lead to cost-savings for EMS agencies but also keep units available for true medical emergencies.

Recommendations:

Agencies:

- EMS Agencies should consider partnering with local hospitals or health organizations to provide community PCP awareness campaigns.
- Community campaigns to secure a PCP can be held at (but not limited to):
 - Health fairs
 - National Night Out events
 - Fire Prevention week events
 - Open houses
 - Emergency room can provide information/education upon patient discharge

Counties and Municipalities:

- Counties and municipalities could assist EMS agencies and local health organizations in coordination of community campaigns.



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TOOL #18

DELIVERY METHODS: CROSS-TRAINED RESPONDERS



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban / U: Urban P: Paid / V: Volunteer
Area:	Cross-Trained Responders	R-S-U/V-P
Type:	Recommendations	

Introduction:

Cross-trained responders can fill in the provider shortage gaps where they exist.

Discussion:

Cross-trained responders, whether they be law enforcement personnel, municipal workers, or fire department staff that are out in the community during their regular work shifts, can usually provide emergency medical services prior to the arrival of transport units. This can lead to improved patient outcomes but can also decrease the need for transport (and tying up EMS units) if it is determined that the patient can be treated on-scene and released, or if there is no need for transport.

Benefits can include:

- Patient care is started sooner, which can lead to shorter hospital stays and more positive patient outcomes.
- EMS on-scene time is decreased or eliminated, allowing for units to be placed in service more quickly.
- Increased community support for services.
- Removing the need for repeat calls from patients to the 911 center.
- Assisting municipalities in meeting their requirement to provide EMS service under the borough and township codes of Pennsylvania.

Best practice: Genessee County, Michigan, Sheriff program

The Office of Genessee County (Michigan) Sheriff Paramedic Division is funded through the Genessee County Paramedic Millage and the only agency in the state where officers are also paramedics. All staff are certified police officers and licensed paramedics in the State of Michigan. The Paramedic Division utilizes the life-saving device known as the LUCAS chest compression device. In 2016, the Paramedic Division responded to over 23,000 911 calls involving medical emergencies.

Contact: Office of Genessee County Sheriff Paramedic Division
1002 South Saginaw Street
Flint, MI 48502
Non-Emergency: 810-257-3422
Administration: 810-257-3406



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U: Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Cross-Trained Responders	
Type:	Recommendations	

Recommendations:

Counties and Municipalities:

- Counties and municipalities could consider programs that provide cross-trained responders within fire, law enforcement, and municipal employees.
- Counties and municipalities could research funding methods for support of cross-trained responder programs.



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TOOL #19

DELIVERY METHODS: EMERGENCY TRIAGE, TREAT, AND TRANSPORT MODEL (ET3)



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Emergency Triage, Treat, and Transport (ET3)	R-S-U/V-P
Type:	Model Programs/Best Practices	

Introduction:

EMS units are occasionally dispatched to treat and transport a patient who might not need emergency department care, thereby tying up resources that might be needed for more urgent patients.

The Emergency Triage, Treat, and Transport (ET3) Model is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service beneficiaries following a 9-1-1 call. The goals of the Model are to provide person-centered care, increase efficiency in the EMS system, and encourage appropriate utilization of emergency medical services.

Discussion:

ET is a payment model providing greater flexibility for EMS when patients call 911 but don't necessarily need to be transported to a hospital emergency department. Triage of patients' needs is completed for determination of further treatment and/or transportation. Treatment could occur for issues that are within the scope of practice of EMT/Paramedics following a consultation with a doctor.

Transportation would be made to the appropriate facility for further patient care. Under the ET3 Model, the Centers for Medicare & Medicaid Services (CMS) will test two new ambulance payments, while continuing to pay for emergency transport of a Medicare beneficiary to a hospital Emergency Department (ED) or other destination covered under current Medicare requirements. Under the ET3 Model, Medicare will pay model participants, who are Medicare-enrolled ambulance suppliers and hospital-owned ambulance providers to:

- Transport a beneficiary to an Alternative Destination Partner such as a primary care doctor's office or an urgent care clinic (Transport to an Alternative Destination Partner), or
- Initiate and facilitate beneficiary receipt of a medically necessary covered service by a Qualified Health Care Partner or Downstream Practitioner at the scene of a 9-1-1 response, either in-person on the scene or via telehealth (Treatment in Place).

See: <https://innovation.cms.gov/innovation-models/et3>

Recommendations:

Agencies, Counties and Municipalities

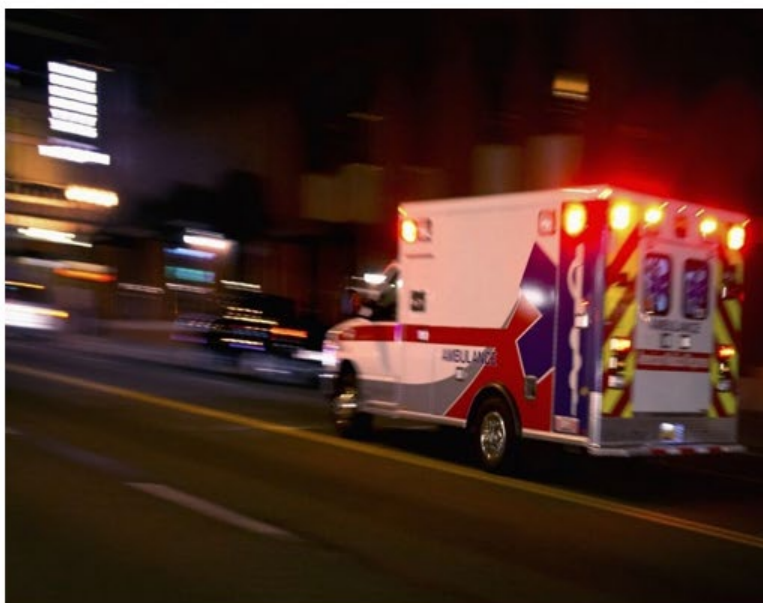


EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Emergency Triage, Treat, and Transport (ET3)	
Type:	Model Programs/Best Practices	

- Research the ET3 model.
- Facilitate discussion with local EMS agencies, hospitals and regional medical command about the ET3 model and whether it may be an effective model for local services.



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TOOL #20

DELIVERY METHODS: INTERMEDIATE ADVANCED LIFE SUPPORT



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EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U: Urban P: Paid / V: Volunteer
Area:	Intermediate Advanced Life Support	R-S-U/P-V
Type:	Model Program/Best Practices	

Introduction:

Intermediate Life Support (IALS) is a level of training for prehospital care providers. IALS is classed as mid-level emergency medical care provided by trained first responders who receive more training than basic life support providers (EMT-Basics, Basic First Responders and First-aid providers), but less as advanced life support providers (such as Paramedics).

Discussion:

IALS allows EMS providers to give a higher level of patient care than basic life support EMTs. The training for IALS certification costs less than paramedic training and is shorter in length, allowing providers to be certified faster thus putting them out in the field faster.

Lancaster Public Safety Answering Point (PSAP) worked with the Emergency Health Services Federation (EHSF) on the intermediate life support (ILS) project.

Benefits include:

- More expedient and cost-effective training.
- Advanced life support (ALS) units would have increased availability for higher acuity calls.
- Increased pool of trained personnel.

Lancaster County provided the following information:

The direction from the EHSF to the PSAPs has been as follows:

- The nomenclature to be used for IALS dispatching is a class 1i or class 1 intermediate.
- When a dispatcher, based on medical protocol, determines a caller's needs meet one of the approved determinants for an IALS dispatch and an IALS resource is available in the response area, then IALS can be dispatched for the patient in lieu of an ALS unit.
- When a dispatcher, based on medical protocol, determines a caller's needs meet one of the approved determinants for an IALS dispatch and an IALS resource is not available in the response area, then an ALS unit will be dispatched for the patient.
- Determinants for an IALS dispatch have been selected because the training, scope, and protocols of the AEMT can effectively manage the patient's needs based on the EMD screening process.
- The EHSF (EMS Council) is aware there are some additional determinants where the AEMT is capable of effectively managing the patient's needs. However, Lancaster PSAP is easing into this change. Additional determinants may be assigned for an IALS response overtime.



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Intermediate Advanced Life Support	R-S-U/P-V
Type:	Model Program/Best Practices	

Explanation of EMD Dispatching System

Within the dispatching system, a dispatching protocol identifies a type of patient's need/condition. For example, protocol one is abdominal pain/problems. Within this one dispatching protocol, there are ten different determinants for dispatching. The determinants provide clarification to what is occurring with the patient's need/condition. For example, abdominal pain/problems – not alert or abdominal pain/problems – fainting or near fainting greater than or equal to 50-years old. Each determinant is assigned a specific type of response (i.e., class 1, class 1i, class 2, or class 3)

Concern Regarding IALS Dispatch for Cardiac Arrest Patients

Among the thirty-three different dispatching protocols, there are forty-five approved determinants for dispatching at the IALS level. There are no protocols where all determinants generate a class 1i dispatch. One area of concern for Lancaster County is IALS dispatched for cardiac arrest patients. In protocol nine for cardiac arrest, there are nine determinants for dispatch. Only one of those determinants is assigned at the IALS level. A cardiac arrest where there is obvious or expected death, such as cold and stiff in a warm environment, decapitation, decomposition, incineration, or non-recent death, can be dispatched at an IALS level instead of the ALS level. The other determinants identify a suspected cardiac arrest – not breathing, uncertain breathing, hanging, strangulation, suffocation, or ineffective breathing will remain an ALS response. Additionally, there will remain two determinants at a class 3 (BLS response) obvious death unquestionable and expected death unquestionable.

IALS Resource Document

Attached is a spreadsheet with resources regarding IALS system planning for the EHSF region.

- The first sheet is the EMD Determinants. This sheet lists every protocol with every determinant and will provide which dispatch class level is approved in the region. Any determinant highlighted in yellow (and will also have IALS in red to the right) means this determinant can be dispatched as a class 1i if there is an IALS level resource available.
- The second sheet is the AEMT Scope. This sheet provides a column for EMT, AEMT, and paramedic to identify the scope differences among the three provider levels.
- The third sheet is the Approved Medications. This sheet provides a column for EMT, AEMT, and paramedic to identify the differences among medications that are required and those permitted to be delivered by each level of certification.
- The fourth sheet is the AEMT Protocols. This sheet lists each of the AEMT protocols and provides skill differences between the EMT and AEMT, as well as the AEMT and paramedic.



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Intermediate Advanced Life Support	R-S-U/P-V
Type:	Model Program/Best Practices	

QA Process

Monitoring how the system works with this change is a priority. Each PSAP has their own internal quality assurance (QA) process. Additionally, as a part of licensure, EMS agencies are to perform quality improvement. The EHSF encourages EMS agencies with IALS level licensure to complete a QA/QI (quality improvement) review of dispatches where IALS is being utilized. It is also encouraged that the agency's medical director is involved with the QA/QI process. The EHSF will also be reviewing IALS usage at a regional level. The EHSF will continue to discuss IALS system planning among the EHSF Medical Advisory Committee, Prehospital Operations Committee, and Regional Communications Committee. These three meeting forums will provide an opportunity to discuss how the system is working and offer suggestions for improvement.

Recommendations:

Agencies and Counties:

Step one – meetings:

EMS Council, PSAP, select group of EMS providers, and the regional medical director should have meetings to discuss the process and protocols.

Step two – create a new unit:

Creation of the unit type Intermediate (IALS) needs to be used in computer aided dispatch (CAD) and on the radio. (Lancaster County made the decision to dispatch IALS as a basic life support (BLS) following the BLS protocols, as this unit type did not fit into their three-tier dispatching model.)

Step three – final decision on protocols and new incident types:

The regional medical director should work with the EMS Council on the translation of changes into the protocols for dispatch to an IALS level of care. From this guideline the PSAP should create new incident types. (Lancaster County had a three-tiered response levels: Class 1 [ALS], Class 2 [BLS light/siren], and Class 3 [BLS no lights/siren]. Lancaster PSAP created a Class 1i for IALS.)

Examples:

Allergic reaction Class 1
Allergic reaction Class 1i (the new incident type)
Allergic Reaction Class 2
Allergic Reaction Class 3

Step four – work behind the scenes:

(Lancaster County PSAP had to update the response zones with the new level of response. A decision was made to keep the IALS response to their home agency calls only. For ALS calls in the county; Class 1 ALS calls go to the closest ALS unit and if a BLS unit is



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Intermediate Advanced Life Support	R-S-U/P-V
Type:	Model Program/Best Practices	

physically closer, they are dispatched as well to render aid until the ALS unit arrives.)

Step five – time to test:

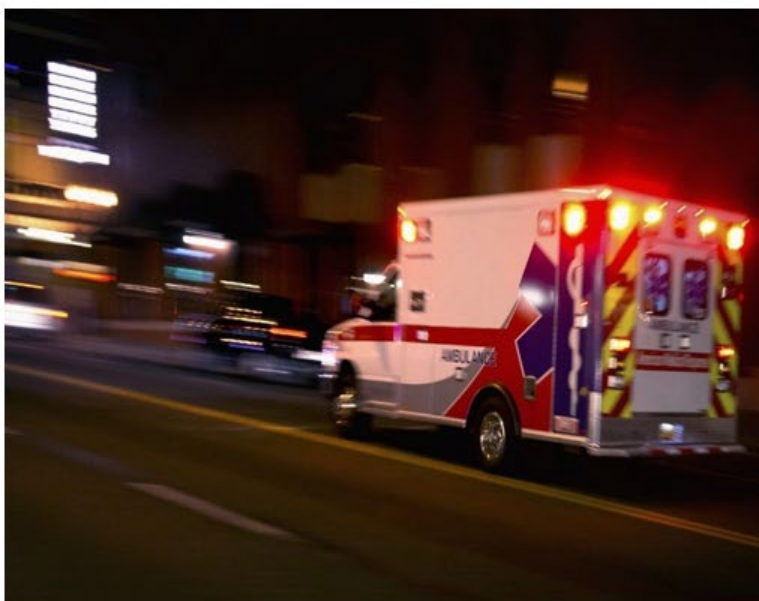
(Lancaster County began with one agency to make sure the software was mapping to the correct incident types. The CAD recommended the correct resource based on the incident type. CAD also reacted properly if the home IALS was not available. This testing was run for up to two months before expanding to other agencies.)

Example:

Attached spreadsheet with identified protocols for IALS response.



Pennsylvania EMS Crisis



January 2023

Toolkit and Recommendations

TOOL #21

DELIVERY METHODS: REGIONALIZATION



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer R-S-U/V-P
Area:	Regionalization	
Type:	Model Programs/Best Practices	

Introduction:

As local resources for manpower and services diminish, discussions on regionalization may take place. If this is an avenue that is pursued, county representatives should have significant conversations with those municipalities and agencies within the suggested regionalization area. It should be cautioned that a regionalization project requires time and may need to be put on the ballot within the affected municipalities.

Discussion:

Regionalization vs consolidation:

- Consolidation involves two or more smaller agencies merging to form a single, larger agency.
- Regionalization involves two or more smaller agencies working cooperatively under an inclusive, unified approach.
- By taking several small EMS agencies and regionalizing them into one larger service, staffing and call volumes could be monitored to address shortages for units and personnel.
- Regionalization does not only apply to stations and response services, but it could also address billing for services, and ordering of supplies and equipment.
- Items for discussion between municipalities and EMS agencies when considering regionalization.
 - Funding sources
 - Policies
 - Administration
 - Protocols
 - Staffing
- Benefits of regionalization
 - Cooperative purchasing
 - Larger staff pool
 - Combined resources (both personnel and equipment)
 - Efficient resource assignment
 - Supports responder competencies
 - Creates a work environment more attractive to responder opportunity

Both urban and rural areas can share resources. Regionalization can also improve paramedic



EMS Tool Kit		Applicability:
Focus Group:	Delivery Methods	R: Rural / S: Suburban/ U:Urban P:Paid / V:Volunteer
Area:	Regionalization	R-S-U/V-P
Type:	Model Programs/Best Practices	

competencies and be used to avoid burnout by moving them between busy and non-busy areas under a joint deployment model. When all agencies under the regionalized model speak with the same voice, greater influence can be attained.

Example Program: Northern Lycoming Regional EMS

Northern Lycoming Regional EMS is a partnership formed by Hepburn, Lewis, Lycoming, and McIntyre Townships in Lycoming County to ensure the three volunteer fire companies which serve those municipalities, Hepburn, Trout Run and Ralston, share responsibility and full-time paid staff to respond to emergency calls in their coverage area. Northern Lycoming Regional EMS is one of the first regional EMS partnerships in Pennsylvania to be initiated and funded directly by municipalities, not just volunteer emergency services agencies.

In addition to each municipality contributing \$30,000 to form the partnership, they were able to secure a \$40,000 donation from EQT and \$100,000 from the Lycoming County Commissioners. Eventually, they plan to have billings make up a majority of their operating budget.

Authority Model

Senate Bill 698 of 2021 would have allowed counties and municipalities to create authorities for the purpose of public safety, and allow that authority to fix, alter, charge and collect rates and other services that the authority provides. This would be similar to municipal authorities, housing authorities, transit authorities, etc. An authority would allow EMS agencies to retain their autonomy, while providing funding and structure support.

Recommendations:

Municipalities and Counties

- Counties and Municipalities could act as a moderator to facilitate the discussions between EMS agencies and municipalities.
- A mechanism for continued discussions between municipalities and agencies could be created and fostered.
- Counties and Municipalities could consider contributing funds to the start-up of regional EMS services.
- Regionalization should be inclusive of all EMS agencies, exploring and utilizing the best practices of each service to benefit patient outcome.



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Appendix K – Sustainable Funding Model for Volunteer Emergency Services



SUSTAINABLE FUNDING MODEL FOR VOLUNTEER EMERGENCY SERVICES

December 4, 2025

INTRODUCTION – INSURANCE BASED EMS

This proposal outlines a fiscally responsible and sustainable funding framework for emergency services across the six-county North Central Pennsylvania region of Cameron, Clearfield, Elk, Jefferson, McKean, and Potter Counties. Emergency response services, particularly volunteer fire and ambulance organizations, are facing mounting challenges, including recruitment shortages, rising operational costs, and uneven local funding mechanisms. Over the past decade, Pennsylvania has experienced a marked decline in volunteer fire companies and growing financial strain on rural EMS providers, with training, equipment, and staffing costs increasing faster than local revenue sources. These trends threaten the reliability and resilience of emergency response across North Central Pennsylvania. In response, this proposal presents innovative, equitable, and regionally coordinated strategies built on predictable and diversified revenue to ensure these vital services remain strong, dependable, and sustainable well into the future.

Implementing insurance-linked fees will require state enabling legislation authorizing carriers to collect and remit an Emergency Services fee. A two-county pilot (e.g., Cameron and McKean) will validate processes and public acceptance before regional scale-up.

Execution will require MOUs among Pennsylvania Insurance Department (PID), PennDOT, and insurers, specifying data exchange, audit rights, a capped 1% administrative retention for carriers, and liability protections for remittance errors.

The 9-1-1 system is the gateway to every emergency response, and its stability is inseparable from the sustainability of fire and EMS services. Yet while 9-1-1 call volumes continue to rise, the statewide surcharge that funds Public Safety Answering Points (PSAPs) has not kept pace with the operational and technological demands placed on dispatch centers. Any long-term solution for emergency services must also include a parallel strategy to strengthen 9-1-1 communications, ensuring that the entire emergency care continuum, from the first call for help to the arrival of trained responders, is adequately and reliably funded. Integrating 9-1-1 into this regional framework ensures that dispatch, fire, and EMS operate as a unified system capable of delivering timely, lifesaving service to every resident of the region.

NOTE: The longstanding Fire Escrow Act provides a strong statewide precedent for this model. Under this Act, insurance companies are required to withhold and remit a portion of fire insurance proceeds to municipalities when a qualifying structure fire occurs, ensuring damaged properties are properly repaired or demolished. This demonstrates that insurers can efficiently collect, manage, and transmit special-purpose fees to local governments under the oversight of the Pennsylvania Department of Community and Economic Development (DCED). By building on this proven mechanism, the proposed Emergency Services Support Fee leverages an existing administrative framework, reducing implementation barriers and offering legislators a familiar, successful model of insurer-municipal cooperation.



DCED's Fire Insurance Escrow List (used by insurers statewide) can be found here:

<https://dced.pa.gov/local-government/fire-emergency-services/fire-insurance-escrow-list/>

- A. **Homeowners and Renters Insurance Fee:** A small, state-authorized Emergency Services Support Fee would be added to homeowners and renters' insurance policies. The fee, based on insured property value tiers (e.g., \$50 annually), would be collected by insurers during policy renewals and remitted to the municipality in which the car and home dwells and/or is registered. The Pennsylvania Insurance Department would oversee administration and compliance. This approach ensures that all insured property owners contribute fairly and creates a predictable annual revenue source.

Not all residents maintain property insurance (e.g., some low-income renters). To ensure universal participation, pair the insurance fee with a hardship contribution option via county treasurers or a minimal property-based fee for uninsured households.

- B. **Vehicle Insurance Fee:** A flat annual Emergency Response Fee (e.g., \$5 per registered vehicle) would be added to auto insurance premiums. Insurers would collect and transmit the funds through existing systems, coordinated with PennDOT data to ensure accurate county-level allocation. Revenue would be remitted directly to the municipality in which the car and home dwells and/or is registered and then distributed by the municipality to local fire and EMS agencies based on population, call volume, and service area coverage.

Fees will be allocated by garaging county using PennDOT registration data; PID will standardize a statewide "Emergency Response Fee" line on policies. Insurers will remit funds quarterly to a state clearing account for onward distribution to counties.

Key Advantages:

- Use existing, regulated insurance infrastructure, no new tax collection system required.
- Ensures broad participation and transparency through state oversight.
- Provides a steady, auditable funding stream dedicated solely to emergency services.
- Minimizes fiscal burden on residents while enhancing local service reliability.

VISION & PURPOSE

The long-term sustainability of emergency services in North Central Pennsylvania depends on strengthening the entire response ecosystem, from 9-1-1 call intake to on-scene fire and EMS operations. The region requires a coordinated, predictable funding framework that ensures residents continue to receive timely, professional emergency response regardless of where they live. This proposal establishes a unified approach that supports volunteer fire companies, EMS agencies, and county 9-1-1 communications centers, recognizing that each component is essential to public safety.

Key Objectives:

- Stabilize and strengthen volunteer fire, EMS, and 9-1-1 dispatch services emergency services.
- Establish equitable, transparent, and regionally consistent funding mechanisms that provide long-term financial sustainability.
- Encourage shared services, regional coordination, and standardized training across all response partners.



- Reduce reliance on local property tax hikes and unpredictable fundraising by shifting to predictable, diversified revenue sources.

PROPOSED FUNDING MECHANISMS

Insurance-linked fees broaden the payer base, while county property assessment fees provide a local control backstop. A hybrid approach (insurance + property + targeted local options) reduces volatility, protects taxpayers from millage spikes, and improves fiscal predictability.

A. Emergency Services Fee via County Property Assessments

Concept: Establish a dedicated Emergency Services Fee as part of the annual property tax bill, structured according to assessed property value. This approach creates a predictable, locally administered revenue stream that ensures every property owner contributes to sustaining fire, EMS, and 9-1-1 readiness across the region.

Two Example Structure:

- \$25: Properties up to \$50,000
- \$50: \$50,001–\$100,000
- \$75: \$100,001–\$200,000
- \$100: Above \$200,001

Benefits: Predictable annual revenue stream distributed to municipalities or regional service districts based on need and call volume.

Administration: This could be structured similarly to the current Earned Income Tax (EIT) collection process, where a State Agency handles collection and remits funds back to the local municipality. It would function like the distribution of foreign fire relief funds and be self-audited through the Annual Financial Report (AFR) in Munstats, under the oversight of the Office of the State Fire Commissioner (OSFC).

To prevent erosion of purchasing power and ensure long-term viability, fee tiers should be indexed every 3–5 years or adjusted automatically based on the Consumer Price Index for All Urban Consumers (CPI-U). This ensures that revenues grow proportionally with inflation, rising emergency service demands, and the cost of equipment, training, technology, and 9-1-1 system upgrades.

B. Insurance-Linked Fee Collection

Concept: Leverage existing insurance billing systems to collect modest emergency services fees across a broader base of homeowners, renters, and vehicle owners.

Homeowners, Renters, Fee Add-On: Add a state-authorized Emergency Services Support Fee (e.g., \$50 annually) to property insurance policies. Funds are remitted to the municipality where the property is located. This ensures that all insured households share responsibility for sustaining local fire and EMS.

Vehicle Insurance Fee: Add a flat Emergency Response Fee (e.g., \$5 per registered vehicle) to auto insurance premiums. Using PennDOT garaging data, insurers remit funds to the appropriate municipality, ensuring equitable, location-based revenue generation.



Administrative Fee: The Pennsylvania Insurance Department (PID) would standardize fee line items and remittance procedures, cap insurer administrative retention at ≤1%, and require quarterly reporting and annual audits. Fees would not affect underwriting or premiums beyond the mandated surcharge.

Advantages: This method leverages existing, regulated infrastructure, expands participation beyond property owners, and requires no new tax collection system, making it politically more feasible and financially more reliable.

C. Regional Service District or Authority

Concept: Create a Regional Emergency Services Authority (RESA), either county-level or multi-county, to coordinate financial management, compliance, distribution, planning, and training.

Function of the Authority:

- Centralize accounting and distribution of property- and insurance-based fee revenues
- Administer grants and shared services agreements
- Support regionalized training, equipment procurement, and facility planning
- Oversee transparency measures such as dashboards and public reporting
- Manage supplemental 9-1-1 support funding for dispatch technology and staffing
- Example: Similar models in parts of New York and Maryland have improved volunteer recruitment and financial stability.

Legal Preparation: Conduct a legal review under Title 40 (Insurance) and Title 53 (Municipalities). Work with the County Commissioners Association of Pennsylvania (CCAP) to draft model enabling legislation for counties wishing to participate.

Oversight Funding:

RESA may retain up to 2% of the revenue collected to cover auditing, reporting, staff support, and administrative infrastructure.

D. Local Revenue Options

Concept: Local governments may adopt complementary strategies to enhance flexibility and strengthen the regional system:

- Optional check-off on county tax bills for residents who wish to contribute more.
- Tourism support fee (e.g., hotel/short-term rental surcharge) to support rural emergency response.
- Business participation program—tiered voluntary support for local employers who benefit from rapid response services.

E. Federal and State Matching

Concept: Local revenues generated through the proposed mechanisms can leverage significant federal and state resources.

- Pursuing matching funds through FEMA's Assistance to Firefighters Grant (AFG), SAFER, and USDA Rural Development.
- Use local fee revenues as leverage to draw down larger state or federal awards.
- Local fees supplement the Act 91 Fire/EMS Grant Program and other state resources.



- Establish a state matching incentive that scales with local fee participation to multiply impact and stabilize multi-year funding. For example, \$1 state match for every \$3 raised locally. This encourages county participation and provides a predictable multi-year funding horizon

System Integration: Matching funds may also support 9-1-1 modernization, including NG911 implementation, GIS upgrades, dispatch center staffing, and technology investments, ensuring the emergency services continuum is strengthened from first call to field response.

F. Integration of 9-1-1 System Funding

Pennsylvania's 9-1-1 system is the first point of contact for all emergency services, yet its primary funding source, the statewide 9-1-1 surcharge, has not kept pace with system costs. Call volume continues to grow, while revenues have plateaued due to outdated fee structures and declining landline use.

This proposal recommends that a portion of the regional emergency services revenue (from property or insurance-based fees) be dedicated to supplementing 9-1-1 operations, including dispatch staffing, technology upgrades, and GIS-based location systems.

Additionally, the Commonwealth should explore a "Next Generation 9-1-1 Modernization Fee", either:

- Added to cellular and broadband service bills to reflect current call behavior, or
- Collected through insurance-based mechanisms, such as a \$1–\$2 annual addition to each auto policy (aligned with PennDOT registration).

This dual-source model ensures that 9-1-1 communications, dispatch, and EMS response are sustainably funded as a single ecosystem, not as isolated silos. Integration would also streamline training, data sharing, and response coordination between dispatch centers and first responders.

DISTRIBUTION FORMULA

Before finalizing any fee structure or allocation formula, a regional feasibility study should be conducted to determine the true sustainable funding requirement for emergency medical and fire services across the six-county region. The study should also analyze 9-1-1 dispatch operations, including staffing, equipment, and technology costs, to determine the full system-wide revenue requirement. Evaluating 9-1-1 as an integral part of emergency response will ensure that long-term planning and fee structures capture the true cost of readiness from call to response. While many EMS providers can estimate their immediate annual budget shortfalls, these figures often reflect short-term survival needs rather than long-term sustainability. The study should analyze operational costs, staffing and recruitment trends, equipment replacement cycles, and inflationary pressures over a ten-year horizon. This assessment would establish a baseline cost model for maintaining reliable service coverage and guide how much revenue must be generated regionally, informing the level and distribution of property-based, insurance-based, or vehicle fees. A data-driven approach ensures that the funding mechanism is not just sufficient for the next budget year but financially sustainable for the next generation of emergency services.

As an example: Funds could be allocated using a weighted formula that considers:

- Population served (40%)
- Call volume (30%)
- Geographic area covered (20%)
- Volunteer recruitment/training metrics (10%)



Partner with PEMAD/CED to analyze five years of call volume, coverage area, and training data to validate weights. Add a five-year formula review clause to recalibrate allocations as service patterns evolve.

This balances fairness and incentivizes participation and performance.

GOVERNANCE AND ACCOUNTABILITY

Confirm statutory authority under Title 40 (Insurance) and Title 53 (Municipalities); adopt annual audit and performance reporting standards; and publish a public dashboard tracking expenditures, response times, training hours, and recruitment outcomes.

- Establish a Regional Oversight Committee (County Commissioners, Fire/EMS representatives, and community members).
- Require annual reporting of revenues, expenditures, and outcomes.
- Provide performance incentives (e.g., additional funds for departments achieving recruitment or training milestones).
- Include representation from county 9-1-1 coordinators or PSAP directors on the Regional Oversight Committee to ensure integrated planning between dispatch and response operations.

LONG TERM SUSTAINABILITY

- Encourage shared services agreements (joint response zones, consolidated dispatch).
- Promote recruitment pipelines via high school and community college partnerships.
- Create volunteer retention benefits (stipends, property tax credits, pension credits).
- Explore public-private partnerships for advanced EMS or equipment leasing.

Authorize automatic fee adjustments when audited year-end deficits exceed a defined threshold (e.g., 8–10% of operating costs), subject to RESA board ratification and public notice.

SAMPLE REVENUE PROJECTION (EXAMPLE ONLY)

The following projection illustrates the potential annual revenue that could be generated across the six-county North Central Pennsylvania region using a flat \$25 Emergency Services Support Fee applied to both households and registered vehicles. These figures demonstrate how modest, broad-based fees can produce substantial and predictable funding to support fire, EMS, and 9-1-1 operations.

This example illustrates that even the lowest-level fee model generates more than \$8.3 million annually, demonstrating the powerful revenue potential of a broad-based emergency services funding framework. Such predictable funding would substantially strengthen staffing stability, equipment replacement cycles, volunteer recruitment incentives, and 9-1-1 modernization needs across the region. The exact fee levels and distribution approach will be determined following the feasibility study and legislative enabling for regional implementation.



County	Households	Avg, Property Fee	Property Fee Revenue	Registered Vehicles	Vehicle Fee	Vehicle Fee Revenue	Total Revenue
Cameron	2,465	\$25	\$61,625	5,578	\$25	\$139,450	\$201,075
Clearfield	36,244	\$25	\$906,100	86,025	\$25	\$2,150,625	\$3,056,725
Elk	13,481	\$25	\$337,025	37,609	\$25	\$940,225	\$1,277,250
Jefferson	18,207	\$25	\$455,175	51,989	\$25	\$1,299,725	\$1,754,900
McKean	16,204	\$25	\$405,100	40,649	\$25	\$1,016,225	\$1,421,325
Potter	6,757	\$25	\$168,925	20,088	\$25	\$502,200	\$671,125
Total	93,358		\$2,333,950	241,938		\$6,048,450	\$8,382,400

*Flat \$25 annual fee Structure for both households and Vehicles

* Households: Census data ACS 2019–2023 (table C25075)

*PennDOT 2024 Registered Vehicles

An Alternative Scenario: The following table represents an alternative, lower-cost vehicle fee paired with a moderate property-based fee. This structure may offer greater political feasibility while still generating meaningful, sustainable revenue for fire, EMS, and 9-1-1 services. Like the prior model, these estimates will be refined through the regional feasibility study to determine the funding levels necessary for long-term system stability... Pennsylvania Counties already have statutory authority to enact a \$5 Local Use Fee on vehicle registrations to support infrastructure projects such as bridge repair and replacement. This existing mechanism provides a strong administrative and legal precedent for collecting a modest per-vehicle Emergency Services Support Fee. The same structure, authorized under Act 89 and administered by PennDOT, could be adapted through new enabling legislation to support fire, EMS, and 9-1-1 services, either in place of or in addition to its current transportation use.

County	Households	Avg, Property Fee	Property Fee Revenue	Registered Vehicles	Vehicle Fee	Vehicle Fee Revenue	Total Revenue
Cameron	2,465	\$50	\$123,250	5,578	\$5	\$27,890	\$151,140
Clearfield	36,244	\$50	\$1,812,200	86,025	\$5	\$430,125	\$2,242,325
Elk	13,481	\$50	\$674,050	37,609	\$5	\$188,045	\$862,095
Jefferson	18,207	\$50	\$910,350	51,989	\$5	\$259,945	\$1,170,295
McKean	16,204	\$50	\$810,200	40,649	\$5	\$203,245	\$1,013,445
Potter	6,757	\$50	\$337,850	20,088	\$5	\$100,440	\$438,290
Total	93,358		\$4,667,900	241,938		\$1,209,690	\$5,877,590

*\$50 annual fee Structure for households and \$5 per registered vehicle

* Households: Census data ACS 2019–2023 (table C25075)

*PennDOT 2024 Registered Vehicles



PUBLIC COMMUNICATION

Public understanding and support are central to sustaining the region's volunteer emergency services and ensuring their long-term viability. Every citizen, whether a homeowner, renter, business owner or traveler, relies on the availability of timely fire, ambulance, and rescue response. Yet many are unaware that most of these lifesaving services in North Central Pennsylvania are provided by volunteers who depend on limited local donations and outdated funding models. The communication strategy should focus on building community ownership of emergency readiness. Through county-wide outreach, local media, and digital dashboards, residents should see how modest contributions translate into tangible outcomes: faster response times, safer equipment, and well-trained first responders.

A strong public communication strategy must therefore focus on building a sense of shared responsibility and community ownership of emergency readiness. Through county-wide outreach, public forums, local media engagement, and transparent digital dashboards, residents should clearly see how modest, predictable contributions translate into meaningful improvements: faster response times, modernized equipment, better-trained responders, and enhanced 9-1-1 capabilities.

Messaging should emphasize that these services are not abstract government programs, they are neighbors helping neighbors, the foundation of public safety, and a shared investment in every household's security and well-being.

CONCLUSION

The long-term sustainability of volunteer fire, EMS, and 9-1-1 services is central to the safety, economic vitality, and quality of life of communities across North Central Pennsylvania. This proposal presents a practical, equitable, and forward-looking framework that secures predictable revenue, promotes regional coordination, and supports the dedicated volunteers and professionals who protect the region every day.

With appropriate enabling legislation, standardized administrative processes, and transparent public reporting, the region can implement a reliable and equitable emergency services funding model without placing undue strain on taxpayers. A phased pilot-to-scale approach ensures the model is tested, refined, and embraced by the communities it serves, building public trust and demonstrating clear measurable benefits from the outset.

By acting now, counties and the Commonwealth can ensure that fire, EMS, and 9-1-1 services remain strong and sustainable not only for today's residents, but for future generations who will depend on the same unwavering commitment to safety and emergency readiness.



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Appendix L – Additional Resources



Workforce Solutions for North Central Pennsylvania

Employer Services for EMS Providers and Municipalities

Workforce Solutions for North Central Pennsylvania serves as the region's workforce development organization, helping employers recruit, train, retain, and upskill workers while connecting individuals to meaningful employment. EMS agencies, municipalities, hospitals, healthcare providers, and other public safety employers have access to a wide range of workforce services designed to address both immediate hiring needs and long-term workforce challenges.

Recruitment and Hiring Assistance

- Recruit qualified candidates through PA CareerLink®.
- Post job openings at no cost.
- Participate in hiring events, career fairs, and targeted recruitment activities.
- Receive candidate screening and referral services.
- Access labor market information to better understand workforce trends, wages, and labor supply.

PASixCareers.com – Regional Career Awareness and Recruitment

Workforce Solutions developed **PASixCareers.com** to help employers connect with the region's future workforce while increasing awareness of careers available throughout North Central Pennsylvania. The interactive website serves students, educators, job seekers, parents, and employers by showcasing career opportunities and regional employers in one location.

Through PASixCareers.com, EMS agencies and municipalities can:

- Create and maintain an employer profile highlighting their organization, culture, and career opportunities.
- Promote careers in Emergency Medical Services, public safety, and related healthcare occupations.
- Share current job openings and internship opportunities.
- Feature videos, photos, and employee testimonials that help job seekers better understand EMS careers.
- Connect with students exploring career pathways before they enter the workforce.
- Increase awareness of local employment opportunities to encourage residents to live and work within the region.



The platform complements traditional recruitment efforts by introducing young people and career changers to in-demand occupations early in the career exploration process, helping employers build a stronger long-term talent pipeline. Workforce Solutions provides technical assistance to employers wishing to participate and continues to expand the platform through partnerships with schools, career and technical centers, libraries, and workforce partners throughout the region.

Workforce Training and Upskilling

- **Incumbent Worker Training (IWT):** Financial assistance to train existing employees and improve workforce skills.
- **On-the-Job Training (OJT):** Wage reimbursement to offset the cost of training new employees.
- Assistance identifying customized training opportunities with regional colleges, career and technical centers, and other training providers.
- Connections to industry-recognized credential programs.

Work-Based Learning

- Internship reimbursement opportunities for eligible employers.
- Development of work-based learning experiences for students and job seekers.
- Coordination with secondary and postsecondary education partners to build career pathways.

Registered Apprenticeships

- Technical assistance in developing Registered Apprenticeship programs.
- Guidance through apprenticeship registration requirements.
- Assistance identifying Related Technical Instruction providers.
- Employer consortium models that reduce administrative burden.
- Connections to apprenticeship funding opportunities.

Business Services and Workforce Planning

- Individual employer consultations to identify workforce challenges.
- Workforce succession planning support.
- Talent pipeline development.
- Labor market analysis and occupational demand information.
- Assistance navigating available workforce funding and incentive programs.

Rapid Response and Layoff Aversion



- Rapid Response services for employers experiencing layoffs or closures.
- Layoff aversion strategies designed to help businesses retain employees.
- Connections to workforce resources during organizational transitions.
- Workforce Solutions for North Central PA and the PA CareerLink system can assist employers and workers affected by business closures, layoffs, downsizing, or other workforce disruptions. Rapid response services can help connect affected workers with career services, employment opportunities, retraining, and other workforce solutions. Layoff aversion strategies may also be explored, when appropriate, to help employers retain workers and reduce or prevent workforce displacement. For the EMS and healthcare sectors, these services may provide an opportunity to retain experienced workers within the region by connecting individuals affected by healthcare closures or workforce reductions with EMS, healthcare and other related employment and training opportunities.

Partnerships and Regional Collaboration

Workforce Solutions serves as a connector between employers and regional partners, including:

- PA CareerLink®
- Educational institutions
- Career and Technical Centers
- Postsecondary training providers
- Economic development organizations
- Industry Partnerships
- State agencies
- Community-based organizations

For EMS providers specifically, Workforce Solutions can facilitate connections to organizations offering expertise in business planning, grant development, housing resources, transportation, economic development, and other supportive services.

Supportive Services for Employees

Recognizing that workforce challenges extend beyond hiring, Workforce Solutions can assist eligible employees with barriers that impact employment success by connecting them with resources related to:

- Transportation
- Housing referrals
- Childcare resources
- Career coaching
- Training assistance



- Supportive service funding (when available)

Industry Partnerships

Workforce Solutions convenes employer-led Industry Partnerships that identify common workforce needs, develop collaborative solutions, and inform training priorities. While EMS is not currently a standalone Industry Partnership, EMS employers are encouraged to participate in regional healthcare workforce initiatives and future sector-based collaborations.

A Regional Partner, not a Duplicate Service

The EMS study identified several recommendations related to recruitment, training, business sustainability, and employer support. Workforce Solutions currently provides many of these services or can connect EMS agencies with organizations that do. Rather than creating new standalone programs, Workforce Solutions recommends leveraging and strengthening existing regional partnerships to maximize available resources, reduce duplication, and ensure employers have a clear pathway to the assistance they need.

Through coordination with organizations such as the North Central Pennsylvania Regional Planning and Development Commission, PennWest Small Business Development Center, educational institutions, healthcare partners, and PA CareerLink®, Workforce Solutions can help EMS providers address workforce challenges through an integrated regional approach that builds on existing expertise and resources.

Regarding Housing

Workforce Solutions recognizes that access to safe, affordable, and stable housing is a significant workforce issue that affects an individual's ability to obtain and retain employment. While Workforce Solutions is not a housing provider or housing development organization, our staff work directly with job seekers to identify housing-related barriers and connect individuals to appropriate community resources and supportive service providers.

The North Central Pennsylvania Regional Planning and Development Commission (NCPRPDC), as the region's designated economic development organization, has taken the lead in assessing regional housing needs. NCPRPDC recently completed a comprehensive Regional Housing Needs Assessment and Market Study and has developed a Housing Hub <https://www.ncentral.com/housing/> to serve as a centralized resource for housing data, planning efforts, funding opportunities, and regional initiatives. The Housing Hub provides valuable information for local governments, developers, employers, and community organizations seeking to address housing challenges across Cameron, Clearfield, Elk, Jefferson, McKean, and Potter counties. The study is intended to support collaborative strategies that improve housing availability and strengthen the region's workforce and economy.



Rather than duplicating these efforts, Workforce Solutions will continue to support individuals through referrals and supportive services while partnering with NCPRPDC and other regional organizations to ensure workforce and housing strategies remain aligned.

Employer Services Coordination – Developed by Workforce Solutions – here is a link to the document: <https://www.workforcesolutionspa.com/categories/business-solutions/pages/business-solutions-intro>

To help employers navigate the wide variety of workforce programs available throughout the region, Workforce Solutions developed an Employer Services Matrix at the request of regional employers. The matrix serves as a single point of reference outlining available workforce services, the purpose of each program, eligibility requirements, and the appropriate point of contact.

The matrix includes information on services such as:

- Recruitment assistance
- Incumbent Worker Training
- On-the-Job Training
- Registered Apprenticeships
- Internship reimbursement programs
- Rapid Response services
- Labor market information
- Business education and training resources
- PA CareerLink® employer services
- Additional workforce and economic development resources

Rather than developing new employer resource guides specific to EMS, Workforce Solutions recommends utilizing and expanding the existing Employer Services Matrix to ensure employers—including EMS providers and municipalities—have access to comprehensive, up-to-date information through a coordinated regional approach. The matrix can be shared with EMS agencies and local governments as a practical resource to connect them with available workforce and business support programs.

This approach reinforces one of the key themes throughout the feedback: building on existing regional assets and partnerships rather than creating duplicative services, ensuring organizations such as Workforce Solutions, the PennWest SBDC, and the North Central Pennsylvania Regional Planning and Development Commission each contribute within their areas of expertise.



Small Business Development and Technical Assistance

The EMS study identified the need for additional business and operational support for EMS organizations, municipalities, and emerging service providers. Workforce Solutions supports this recommendation and encourages leveraging existing regional resources before creating new services.

The **PennWest Small Business Development Center (SBDC)** provides no-cost, confidential consulting and low-cost educational programs to help businesses, entrepreneurs, nonprofit organizations, and public entities strengthen their operations. The SBDC can assist EMS agencies and municipalities with topics such as:

- Strategic and business planning
- Financial management and budgeting
- Cash flow analysis
- Grant readiness and funding strategies
- Business succession planning
- Organizational growth and sustainability
- Marketing and community outreach
- Human resources and operational planning

These services can help EMS organizations build long-term sustainability while allowing workforce development partners to remain focused on talent development, recruitment, training, and employment.



INCUMBENT WORKER TRAINING

*Upskill your workforce.
Strengthen your business.*

Reimbursement assistance for employee training that helps business grow, retain workers, and stay competitive.



**INVEST IN YOUR PEOPLE.
BUILD A STRONGER FUTURE.**



WHO CAN APPLY?

Employers and employees must meet eligibility requirements.



WHAT'S COVERED?

Tuition, training materials, instructor costs, certificate/testing, and more.



EMPLOYER COST SHARE

10% - 50%
based on
business size.



WHY IT MATTERS

Strengthen skills, retain talent, and grow your business.



OPEN TO ALL INDUSTRIES!

Whether you're in manufacturing, healthcare, retail, hospitality, IT, or any other industry - we're here to help you invest in your team.



SCAN TO LEARN MORE

Apply, view guidelines,
and see full details.



814-245-1835



info@ncwdb.org



workforcesolutionspa.com

Equal Opportunity Employer/Program

Auxiliary aids and services are available upon request to individuals with disabilities.

Funded in whole or in part by Federal Funds. Detailed information can be found at:

<https://www.workforcesolutionspa.com/categories/resources/pages/stevens-amendment>





REGISTERED APPRENTICESHIPS

BUILD YOUR WORKFORCE. DRIVE YOUR BUSINESS.

Registered Apprenticeships are a proven solution to develop skilled talent, improve retention, and strengthen your bottom line with a program designed around your business needs.



Customized training.
Stronger results.

THE BUSINESS BENEFITS

BUILD A SKILLED WORKFORCE

Develop employees with the exact skills your business needs - today and in the future

IMPROVE RETENTION

Employees who apprentice are more likely to stay and grow with your company

INCREASE PRODUCTIVITY

Well-trained employees are more efficient, confident, and ready to contribute sooner

EARN RECOGNIZED CREDENTIALS

Apprentices earn a recognized credential that validates skills and strengthens your team's expertise

ACCESS SUPPORT & RESOURCES

We help you navigate the process and connect you with funding and other opportunities



WE'RE YOUR PARTNER

Workforce Solutions for North Central PA partners with the PA Department of Labor and Industry's Apprenticeship and Training Office to help employers design, register, and grow apprenticeship programs that meet your business goals.

WE HELP INDUSTRY PARTNERS:

- ✓ Design programs tailored to your business
- ✓ Navigate registration and compliance
- ✓ Recruit and retain quality talent
- ✓ Access resources and funding opportunities
- ✓ Build a pipeline of skilled, committed employees

**READY TO BUILD
YOUR WORKFORCE?**

Let's get started.



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Workforce Solutions
for North Central PA



Business Education Connect Interest Form

Connect your business with local schools and help students explore careers in our region.

Prefer digital?



Scan to complete online

1 BUSINESS INFORMATION



Company Name

Industry

Contact Name

Contact Title

Phone

Email

Address

2 WE ARE INTERESTED IN

Select all that apply.



- ☐ **Career Awareness Activities**
Career Fairs, Career Days, Industry Days, etc.
- ☐ **Mock Interviews**
Conduct simulated interviews with students at school or virtually.
- ☐ **Career Camps**
Camps focused on specific career areas or student groups.
- ☐ **Financial Reality Fairs**
Interactive budgeting experience based on career choices.
- ☐ **Job Shadowing**
Students observe an employee on the job (typically 3 hours on site).
- ☐ **Guest Speakers**
Share professional stories, knowledge, and experiences with students.
- ☐ **On Site Tours**
Students, parents, and teachers visit your company to learn first-hand.
- ☐ **Skill Discovery**
Students learn specific skills through interactive, hands-on activities.
- ☐ **Parent and Community Engagement**
Engage parents and the community to support student success.
- ☐ **Teacher Experiences**
Help educators see the skills needed in industry to support learning.

3 COUNTIES WILLING TO TRAVEL TO

Select all that apply.



- | | |
|-------------------------------------|------------------------------------|
| ☐ Cameron | ☐ Jefferson |
| ☐ Clearfield | ☐ McKean |
| ☐ Elk | ☐ Potter |

4 JOIN THE PA SIX CAREERS NETWORK



Business Education Connect is part of **PA Six Careers**, a free regional career exploration website. The information on this form helps us connect your business with local schools and may be used to create or update your organization's profile.

- ☐ **Help us create our PA Six Careers profile**
- ☐ **Contact us with more information**
- ☐ **We already have a PA Six Careers profile**

➤ Thank you for helping us grow the future workforce - right here at home! ➤

Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities.
Funded in whole or in part by Federal Funds. Detailed information can be found at: <https://www.workforcesolutionspa.com/categories/resources/pages/stevens-amendment>