Regulatory Analysis Form RECEIVED 99 JAN 29 PM 3:35 INDEPENDENT REGULATORY REVIEW COMMISSION	This space for use by IRRC
(1) Agency Department of Health Bush #2003	IRRC Number:
(2) I.D. Number (Governor's Office Use) 10-143	

(3) Short Title

Emergency Medical Services

(4) PA Code Cite	(5) Agency Contacts & Telephone Numbers
28 PA Code Chapters 1001-1015	Primary Contact: Kimberly Sokoloski Director, Legislative Liaison Office Secondary Contact: Margaret E. Trimble Director, Emergency Medical Service Office

(6) Type of Rulemaking (Check One)	(7) Is a 120-Day Emergency Certification Attached?
✓ Proposed Rulemaking	✓ No
__ Final Order Adopting Regulation	__ Yes: By the Attorney General
__ Final Order, Proposed Rulemaking Omitted	__ Yes: By the Governor

(8) Briefly explain the regulation in clear and non-technical language.

Proposed comprehensive amendments to the Department's regulations promulgated under the Emergency Medical Services Act (EMS Act).

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Section 17.1 of the EMS Act (35 P.S. §6937.1) provides that the Department, in consultation with the Pennsylvania Emergency Health Services Council (Council), may promulgate regulations as may be necessary to carry out the provisions of the EMS Act. Numerous other provisions of the EMS Act contain more narrow grants of authority to the Department to promulgate regulations.

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

Pursuant to Section 6 of the Act of October 5, 1994, P.L 557, No. 82 (Act 82), the Department was supposed to promulgate by June 3, 1996, as final regulations, interim regulations previously adopted as authorized by Act 82.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

It has been nine years since the Department published its initial regulations under the EMS Act. A changed EMS environment in that nine-year time span, statutory amendments, problems brought to the Department's attention in administering the existing regulations, judicial decisions that have clarified the Department's authority and responsibilities under the EMS Act, and a statutory duty to process through the customary rulemaking procedures standards the Department has imposed through interim regulations, present compelling reasons for the Department to pursue comprehensive revisions to its EMS regulations.

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

- Quality of patient care in prehospital setting may be negatively affected secondary to delayed implementation of improved care modalities.
- Increased confusion regarding authority, process and standards relative to emergency medical services.
- Decreased standardization in delivery of services.
- Issues will be more likely solved through judicial process resulting in increased costs and decrease in prehospital provider numbers.
- Constrained resources will be redirected away from system improvement toward conflict resolution for issues not presently addressed by regulations.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

All citizens and visitors of Pennsylvania are potential beneficiaries of these improved regulations.

Licensed ambulance services (1,113) responded to more than 1.3 million calls in 1996. Improved quality care will be delivered to the users.

Mortality reduction will be made through emergency medical services systems improvement particularly for the mortality in trauma (4,274 deaths in 1996) and in acute heart attack such as acute myocardial infarction (13,439 deaths in 1996).

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(13) CONTINUED

EMS pre-hospital personnel will have improved opportunities to receive diverse continuing education because the concept of what constitutes qualifying continuing education programs has been broadened to include continuing education credit assigned to self-study courses and courses completed through an organization with national or state accreditation to provide education.

EMS personnel certified in other states will find it easier to apply for certification in Pennsylvania. An individual's certification materials will be evaluated through the endorsement process.

Although medical command physicians who are not board certified in emergency medicine must complete additional courses to maintain recognition as a medical command physician fewer courses are now required. Currently, a physician (not board certified in emergency medicine) has to renew ATLS and ACLS certification on a four-year and two-year basis. Of the 3200 medical command physicians, approximately 23% (736) of these physicians are board certified in emergency medicine and therefore are not required to take additional courses. The regulations for medical command physicians have been revised to require completion of an ATLS course on a one time only basis for physicians who are not certified in emergency medicine. Costs for ATLS courses may range from $125 - $325, and these courses are not readily available in rural areas of the Commonwealth. Physicians frequently have to travel to distant parts of the state in order to complete ATLS courses. The proposed regulation would reduce physician costs every four years ranging from $308,000 - $800,800.

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(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

As set forth in the interim regulations, EMS personnel (including first responders and EMTs) who choose to re-certify through the continuing education process must complete a specific number of hours of instruction prior to the expiration date of the three year certification period. EMT-paramedics and PHRNs must complete 18 hours of instruction per calendar year. The number of hours of instruction would not be increased; however, the Department has proposed to revise the requirements. At least 50% of the required hours would have to be in two core areas: medical and trauma education. This may pose some hardship to the prehospital provider who does not choose continuing education offerings based on content. Availability of approved programs in some areas of the state will be closely monitored to ensure access and availability of courses. Also, a grace period would be provided. The Department believes that the negative effect of this regulatory change would be offset by the increase in types of courses and content now eligible for approval by the Department.

The proposed regulations identify responsibilities for continuing education sponsors to meet regarding retention of student records and maintenance of record attendance through a check-in/check-out process. Even though this may present a minimal hardship to the continuing education sponsor, this will ensure course integrity so that an EMS provider is not awarded continuing education hours of instruction inappropriately.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

Persons: Approximately 36,000 emergency medical technicians (EMTs); 6,700 first responders; 7,000 EMT-paramedics; 3,200 medical command physicians, and 736 prehospital registered nurses.

Entities: 1,113 licensed ambulance services, 168 medical command facilities and 1,297 approved continuing education sponsors.

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(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

In developing the proposed amendments, the Department pursued early and meaningful input from the regulated community. On December 20, 1996, a first draft of proposed amendments was forwarded to the Council for its comments and recommendations. The Council circulated that draft throughout the State' s EMS community, and solicited input from its membership. The Council submitted its comments to the Department in June 1997. On June 28, 1997, the Department published in the *Pennsylvania Bulletin* notice that it was seeking early public input. Comments were received and a public hearing was conducted on August 4, 1997. On April 1, 1998, the Department distributed a second copy of draft proposal, conducted a public meeting to provide an overview of the second draft of proposed regulations, and solicited comments. Several hundred comments were received. Some of the commentors include the Council, regional EMS councils, the Pennsylvania Ambulance Association, HAP, ambulance services, the Pennsylvania Paramedic Association, and hospitals.

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(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

No additional costs to the regulated community are anticipated. Some efficiencies are anticipated by streamlining processes for ambulance service licensure, improved flow of research proposals and improvement in recognizing out-of-state providers and programs. The actual dollars saved cannot be estimated well. Time saved in recognition of out-of-state certified providers and timely issuance of Pennsylvania certification materials (to these individuals) will provide them with the opportunity to volunteer or work more readily in the Pennsylvania EMS system. It is estimated that the regional councils could process and issue certification materials within five to ten business days.

Medical command physicians who are not board certified in emergency medicine must complete additional courses to maintain recognition as a medical command physician. Currently, a physician (not board certified in emergency medicine) has to renew ATLS and ACLS certification on a four-year and two-year basis. Of the 3200 medical command physicians, approximately 23% (736) of these physicians are board certified in emergency medicine and therefore are not required to take additional courses. The regulations for medical command physicians have been revised to require completion of an ATLS course on a one time only basis for physicians who are not certified in emergency medicine. Costs for ATLS courses may range from $125 - $325, and these courses are not readily available in rural areas of the Commonwealth. Physicians frequently have to travel to distant parts of the state in order to complete ATLS courses. The proposed regulation would reduce physician costs every four years ranging from $308,000 - $800,800.

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(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

Local governments not presently involved in emergency medical services will be increasingly important to decisions regarding the allocation of services and utilization of EMS resources. This increased participation should not increase costs.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including and legal, accounting, or consulting procedures which may be required.

Implementation, processing and monitoring of the continuing education program will increase at the state level requiring an additional staff position to assist in the management of the improved continuing education program. Additionally, the Department will need to develop new continuing education programs and materials as well as revise existing programs and materials. Specifically, all currently approved continuing education courses (approximately 700) will be re-evaluated and assigned new course numbers to reflect trauma and/or medical credit hours needed by EMS personnel for re-certification. The Department will also revise the reporting/record keeping process for continuing education requirements and courses. Revision of forms and printing will be associated costs. One computer work system for the additional staff person will be needed.

The Emergency Medical Services Office (EMSO) will incur additional costs for the continuing education program because the proposed revisions to the regulations will require updating of the continuing education software program. All existing continuing education courses will be evaluated for credit hours. Currently EMS personnel receive credit hours for these courses. When the revisions to the regulations are adopted, continuing education hours will be divided into three categories - medical, trauma, and other. The changes in course designation and credit hours, and the new processing software required, will cost about $25,000 in software system redesign. An additional $5,500 will be required for revised forms (approximately 200,000 scan forms are used annually). The new computer hardware to support this program will cost about $3,000. The total estimated costs for these expenditures are $100,500 for FY 1998-99 including $67,000 for personnel. Subsequent costs are estimated and shown in question 20.

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community		200,200	200,200	200,200	200,200	200,200
Local Government						
State Government						
Total Savings		200,200	200,200	200,200	200,200	200,200
COSTS:						
Regulated Community						
Local Government						
State Government		100,500	70,484	74,149	78,004	82,061
Total Costs		100,500	70,484	74,149	78,004	82,061
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses		0	0	0	0	0

(20a) Explain how the cost estimates listed above were derived.

COSTS: One additional staff to the Emergency Medical Services Office: EMS Program Specialist 2 with a pay grade 9 (annual salary and benefits -- $67,000).

One time computer system upgrade for continuing education program data and information processing -- $33,500.

Program staff costs for FY +2 to FY+5 were adjusted 5.2% (3% raise and 2.2% step increase).

SAVINGS: Costs for ATLS courses may range from $125 - $325, and are not readily available in rural areas of the Commonwealth. The proposed regulation represents a cost avoidance every four years ranging from $308,000 - $800,800.

(20b) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY - 3	FY - 2	FY - 1	Current FY
Planning				
Licensure (Ambulance Services)				
Total Expenditures*	9,529,931	6,332,881	8,475,806	6,218,330**

*Includes total expenditures for implementing the EMS program.
**Includes total expenditures through April 30, 1998.

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

While the additional cost for these proposed revisions is approximately $100,000 for the start up year, the cost is much less for succeeding years. For these invested dollars, the continuing education program will be improved and will include more diverse opportunities for EMS prehospital personnel to complete a variety of continuing education programs thereby improving the knowledge and skills to enhance patient care. The regulations will provide regulatory relief to over 2,400 medical command physicians because they will not have to maintain additional course requirements such as ATLS. Barriers to reciprocity to out of state providers will be minimized thereby improving options to increase provider population. Opportunities to deliver improved care through research and enhanced delivery of care are supported. The improvements measured in lives saved and disability avoided far outweigh the costs generated. The revised regulations will also enhance the existing EMS system, thus benefiting all citizens and visitors of the Commonwealth.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Non-regulatory alternatives were not options. The regulations were a requirement to address the mandates as prescribed in Act 45, as amended by Act 82. Wherever possible, regulation was minimized. These regulations will provide some additional legal protection to EMS providers. Litigation in the absence of regulations would be very costly, but secondarily it would reduce the number of providers in the EMS systems. This was not a viable alternative. Self-regulation by numerous agencies and individuals would create high risk to the consumers when they are most vulnerable and dependent. This was also not a viable alternative.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

Same as answer to question 22 above.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

There are no federal regulations. Many national standards are more stringent, e.g., continuing education requirements, staffing of ambulance, etc.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

Many states have higher standards in areas noted in the response to question #24. In many respects, these regulations will support parity with other states.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

The regulations will not conflict with other regulations, but hospital and 911 regulations must complement these EMS regulations to provide comprehensive guidelines.

(27) Will any public hearings or information meetings be scheduled? Please provide the dates, times, and locations, if available.

Public meeting held at Rachel Carson State Office Building on April 1, 1998, with 51 in attendance.

The 16 regional EMS councils each held informational town meetings within their geographical areas.

3,000 copies of the draft rules and regulations have been distributed to EMS stakeholders for comments since April 1, 1998.

The draft was also entered on the Pennsylvania Emergency Health Services Council web site on April 1, 1998.

Over 50 computer disks of the draft were distributed to requestors.

April 1, 1998 -- Medical Advisory Committee, Pennsylvania EHS Council

April 2, 1998 -- Pennsylvania Trauma Systems Foundation Information Meeting

April 3, 1998 -- Paramedic Association

May 8, 1998 ---Ambulance Association

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.

Medical command facility medical director and medical command physician recognition applications will be revised. The Medical Command Accreditation Manual will require updating, reprinting and distribution. The Department will also need to revise, reprint and distribute the ambulance licensure application and the Ambulance Licensure Policy Manual

The existing 700 continuing education programs and materials will need to be re-evaluated and assigned new course numbers to reflect trauma and/or medical credit hours needed by providers for recertification. Revision of course forms will be completed and the reporting/record keeping process for continuing education requirements and courses will also be revised.

Forms will be revised accordingly based upon approval of the proposed regulations.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

- Flexible regulatory requirements for ambulance services in rural areas.
- More favorable funding for training and ambulance services equipment for ambulance services in rural areas.
- Pediatric training required for medical command physicians.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

Anticipated effective date for regulations: Spring, 1999.

Continuing education requirements for specific medical and trauma credit

1) Paramedics: first calendar year after regulation implementation (Spring, 1999),

2) continuing education requirements for medical and trauma credits: first calendar year after regulation implementation

3) Prehospital Registered Nurse, First Responder and Emergency Medical Technician: first recertification cycle after regulation implementation.

(31) Provide the schedule for continual review of the regulation.

Annual review as mandated by Act 45.

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Copy below is hereby approved as to form and legality. Attorney General.	Copy below is hereby certified to be a true and correct copy of a document issued, ~~prescribed~~ or promulgated by:	Copy below is hereby approved as to form and legality. Executive or independent Agencies.
BY ______ DEPUTY ATTORNEY GENERAL	DEPARTMENT OF HEALTH (AGENCY)	BY ______
OCT 27 1998 DATE OF APPROVAL	DOCUMENT/FISCAL NOTE NO. 10-143	10/1/98 DATE OF APPROVAL
	DATE OF ADOPTION: ______	(Deputy General Counsel) ~~(Chief Counsel, Independent Agency)~~ (Strike inapplicable title)
	BY: Daniel F. Hoffmann, FACHE	
☐ Check if applicable. Copy not approved. Objections attached.	TITLE: Secretary of Health	☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

PROPOSED RULEMAKING

DEPARTMENT OF HEALTH

TITLE 28. HEALTH AND SAFETY

[28 PA. CODE CHS. 1001-1015]

Emergency Medical Services

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The Department of Health (Department) hereby gives notice that it is proposing to amend its regulations at 28 Pa. Code Part VII (relating to emergency medical services), §§1001.1-1013.7, as set forth in Annex A hereto.

PURPOSE AND BACKGROUND

Interim regulations were published on September 2, 1995, to facilitate implementation of the Act 1994-82 (Act 82) amendments to the Emergency Medical Services Act (act) (35 P.S. §§6921-6938). Section 6 of Act 82 authorized the Department to bypass certain rulemaking procedures to adopt the interim regulations, with the caveat that those regulations later be resubmitted through the customary rulemaking procedures.

Amendments to regulations dealing with subject matter addressed by the act, but not addressed by the Act 82 amendments, were not adopted through the interim rulemaking process. The interim regulations were required to be limited in scope to the parameters of Act 82.

Following the Department's adoption of the interim regulations, pursuant to House

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Resolution 92 of 1995, the House Health and Human Services Committee issued a Final Report on the Statewide emergency medical services (EMS) system, addressing the effectiveness of the system and problems in its administration. That report was distributed in November 1996. Thereafter, the Department commenced a review of its EMS regulations in their entirety.

In developing the proposed amendments, the Department pursued early and meaningful input from the regulated community, as required by Executive Order 1996-1 (relating to regulatory review and promulgation). On December 20, 1996, a first draft of proposed amendments was forwarded to the Pennsylvania Emergency Health Service Council (Council) for its comments and recommendations. The Council circulated that draft throughout the State's EMS community, and solicited input from its membership. The Council submitted its comments to the Department in June 1997.

On June 28, 1997, the Department published in the *Pennsylvania Bulletin* notice that it was seeking early public input with respect to its amendment of the EMS regulations, that members of the public could secure a copy of the Department's preliminary draft, and that a public meeting to discuss amendments would be held on

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August 4, 1997. Comments were received and the public meeting was convened as scheduled.

Pursuant to House Resolution 186 of 1997, the Legislative Budget and Finance Committee (LBFC) conducted a performance audit, beginning on or about July 29, 1997, of how monies from the Emergency Medical Services Operating Fund were being allocated and spent by the Department and other participants in the Statewide EMS system to whom the funds were distributed by the Department. The LBFC issued its report on February 24, 1998.

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On April 1, 1998, the Department distributed, and conducted a public meeting to provide an overview of, a revised set of draft proposed regulations. Comments were solicited through May 1, 1998.

In developing these proposed regulations the Department thoroughly considered the Final Report of the House Health and Human Services Committee based upon House Resolution 92, the Final Report of the LBFC based upon House Resolution 186, the written comments received from the Council and the public, and the oral presentations made by persons who participated in the public meetings. The Department was further assisted by extensive ongoing consultation with the Director of the Council following the August 4, 1997 public meeting.

By this proposed rulemaking the Department is meeting its statutory duty to subject the regulations it adopted through the interim rulemaking process to the standard regulatory oversight procedures. The Department is also taking this opportunity to propose amendments to those regulations, as well as to other regulations it was not authorized to amend through the interim rulemaking process.

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It has been nine years since the Department published its initial regulations under the act. A changed EMS environment in that nine-year time span, statutory amendments, problems brought to the Department's attention in administering the existing regulations, judicial decisions that have clarified the Department's authority and responsibilities under the act, and a statutory duty to process through the customary rulemaking procedures standards the Department has imposed through interim regulations, present compelling reasons for the Department to pursue comprehensive revisions to its EMS regulations at this time.

SUMMARY

The regulations that have been adopted to facilitate administration of the act are presented in the following seven chapters: Chapter 1001 (relating to administration of the EMS system), Chapter 1003 (relating to personnel), Chapter 1005 (relating to licensing of BLS and ALS ambulance services), Chapter 1007 (relating to licensing of air ambulance services - rotorcraft), Chapter 1009 (relating to EMS medical command medical facilities), Chapter 1011 (relating to accreditation of training institutes), and Chapter 1013

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(relating to special event EMS). The proposed amendments would retain each of these chapters. Some of the titles would be revised. The proposal would also add Chapter 1015 (relating to quick response services).

Chapter 1001. Administration of the EMS system

This chapter explains the purpose of the Department's EMS regulations, defines terms used in the regulations, identifies standards for the Statewide and regional EMS development plans, prescribes criteria for the Department's distribution of funds, establishes EMS data collection and reporting responsibilities, sets standards for quality assurance programs to monitor the delivery of EMS, creates standards for the integration of trauma facilities into the Statewide EMS system, explains and imposes duties on the regional EMS councils, addresses the relationship between the Department and the Council, and imposes restrictions on EMS research by persons regulated under the act.

Subchapter A. General Provisions

Section 1001.1 (relating to purpose) would be amended to clarify that the

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Department does not use regulations to address or carry out all of its responsibilities under the act. For example, some of its responsibilities are addressed by contract.

Section 1001.2 (relating to definitions) would be amended to revise several definitions to read more clearly. Definitions would be added for "advanced pediatric life support (APLS) course," "ambulance call report," "ambulance identification number," "board certification," "continuing education," "direct support services," "Emergency Medical Services Operating Fund (EMSOF)," "EMS training institute," "Medical Command Base Station Course," "medical treatment protocols," "pediatric advanced life support (PALS) course," "physician," "public safety answering point (PSAP)," "registered nurse," "service area," and "Statewide BLS treatment protocols."

The definitions would explain what an APLS course, a PALS course, and the Medical Command Base Station Course are. It is proposed that successful completion of an APLS or a PALS course, combined with other criteria, be required for a physician to become a medical command physician or an advanced life support (ALS) service medical director if the physician is not board certified in emergency medicine. Completion of the Medical Command Base Station Course has been and would continue to be a requirement

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for both physician positions.

"Ambulance call report" would be the label the Department assigns to the form or other reporting mechanism, perhaps through electronic data entry, by which it collects standardized patient data and other information from ambulance services pursuant to §5(b)(3) of the act (35 P.S. §6925(b)(3)).

"Ambulance identification number" would replace the present term "vehicle identification licensure number." The change would be made because the Department does not technically license ambulances, and to distinguish the term from the term "vehicle identification number" used by the Pennsylvania Department of Transportation to identify vehicles.

"Board certification" would identify private certifying bodies recognized by the Department wherever the regulations specify that a criterion for qualifying for a certain position, such as a medical command physician, requires a board certification in a medical specialty. Reference to these certifying bodies would not, however, preclude the Department from considering persons with certifications issued by other private certifying

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bodies. The criteria for issuing certifications used by the specified entities would comprise the baseline standards. The Department would grant an exception to the regulation, under §1001.4 (relating to exceptions), if a candidate could establish that the certification that person received from another certifying agency was issued pursuant to standards equal to or greater than those employed by the private certifying bodies referenced in the definition.

A definition of "continuing education" would be added to identify the objectives that learning activities would need to be designed to achieve to be recognized by the Department for continuing education purposes.

"Direct support of EMS systems" would be defined because §17 of the act (35 P.S. §6937), which requires that at least 75% of all funds available to the Department for the initiation, expansion, maintenance, evaluation and improvement of EMS systems be allocated for the direct support of EMS systems, does not define what is encompassed in the direct support of EMS systems. The lack of a definition was identified as a problem in the LBFC report.

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"EMSOF" would be defined to clarify that in the context of the regulations the term refers to only that portion of the Emergency Medical Services Operating Fund appropriated to the Department for EMS purposes, and does not include that portion of the appropriation assigned to the Catastrophic Medical and Rehabilitation Fund (Head Injury Program).

"EMS training institute" would be defined to clarify that where that term is used in the regulations it applies only to institutes accredited to offer training leading to mandatory certifications and recognitions issued by the Department under the act. For example, the term does not apply to an institution that offers continuing education exclusively.

Sections 5(c) and 11(h) and (i) of the act (35 P.S. §§6925(c) and 6931(h) and (i)) address the establishment of and compliance with medical treatment protocols. The definition of "medical treatment protocols" would clarify what is encompassed by this term and replace the definition of "medical protocols." The definition of "Statewide BLS medical treatment protocols" would refer to basic life support (BLS) treatment protocols the Department has developed for the Statewide use of prehospital personnel when they

are providing BLS services.

The terms "physician" and "registered nurse" would both be defined to mean a person licensed in the Commonwealth to practice the applicable profession, with a current renewal or registration of that license. Consequently, wherever those terms would appear in the regulations additional language pertaining to the license being a current Pennsylvania license would not be required.

"Public safety answering point" (PSAP) would be used to label entities that dispatch ambulance services and other emergency response resources.

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A proposed definition of "service area" is included to clarify to which political subdivisions an ambulance service must provide notice when it is going out of business. An ambulance service has a duty under §12(q) of the act (35 P.S. §6932(q)) to notify the chief executive officer of each political subdivision in its service area at least 90 days prior to discontinuing service in that area.

The definitions of "air ambulance medical crew member," "ambulance trip report number," "BLS training institute," "closest available ambulance," "EMS council," "field internship," "field preceptor," "incident location," "licensing agency," "medical protocols," "medical service area," "on-line communication," "Pennsylvania Field Protocols for BLS," "prescribing physician," "primary response area," "quick responder," "transfer agreements," and "vehicle licensure identification number" would be removed. These terms would either no longer appear in the regulations, be replaced by other terms, or not require definition as their meanings would be either clear or otherwise explained in the regulations.

Section 1001.3 (relating to applicability) identifies, in general terms, who is affected by Part VII (relating to emergency medical services) of the Department's

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regulations. No substantive amendments are proposed.

Section 1001.4 (relating to exceptions) provides a process for persons to seek an exception to a regulatory requirement that is not also directly imposed by the act. It would be amended to clarify that an exception to a regulation in this part may be granted by the Department, on its own initiative, when it determines that the substantive requirements of §1001.4 have been satisfied. Currently, the regulation provides that an exception may be granted only upon application to the Department.

Section 1001.5 (relating to investigations) provides that the Department may investigate accidents involving ambulances and complaints involving prehospital personnel and EMS providers. These references do not adequately convey the scope of the Department's investigatory activity under the act. The section would be revised to more fully describe the scope of the Department's investigatory activities.

Section 1001.7 (relating to comprehensive regional EMS development plan) would be new. It would require each regional EMS council to develop a regional plan for coordinating and improving the delivery of EMS in the region for which it has been

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assigned responsibility by the Department. It would require that the regional EMS council give notice to the public and an opportunity for comment before submitting the plan to the Department for approval.

Section 1001.6 (relating to comprehensive EMS development plan) would be amended to provide that the regional EMS development plans would be incorporated into the Statewide EMS development plan. The section would also be amended to require public notice and an opportunity for comment before the Department's adoption of a Statewide plan.

The Statewide EMS development plan serves as a blueprint for how EMS problems are to be addressed and how EMS systems are to be maintained in the Commonwealth.. Section 10(a) of the act (35 P.S. §6930(a)) requires the Department to enter into contracts for the initiation, expansion, maintenance and improvement of EMS systems which are in accordance with the Statewide EMS development plan. This document is a planning document which impacts on the Department's distribution of funds for EMS systems. It is not a vehicle by which the Department is permitted to bypass the rulemaking process to regulate providers of EMS. Consequently, the

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Department would not be regulating providers of EMS through this document.

Subchapter B. Award and Administration of Funding

The title of this subchapter would be revised to replace the term "Contracts" with "Funding." This change is proposed because the scope of this chapter is not and would not be confined to addressing the distribution of funds through contracts exclusively.

Section 1001.21 (relating to purpose) describes the purpose of the subchapter on funding. It would be amended to recognize that §10(j) of the act (35 P.S. §6930(j)) permits the Department to contract with entities to assist the Department to comply with the provisions of the act.

Section 1001.22 (relating to criteria for funding) identifies criteria for the distribution of EMSOF funds to contractors and other recipients of those funds. It would be amended to acknowledge that not all funding provided by the Department is through contracts--such as the distribution of some of the EMSOF monies to providers of EMS. These are more in the nature of grants. Some of the funding priorities would also be

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revised.

Section 1001.23 (relating to allocation of funds) identifies some of the factors that are considered in determining the amount of funds to be distributed to eligible recipients. No substantive amendments are proposed.

Section 1001.24 (relating to application for contract) pertains to applications for contracts to plan, initiate, maintain, expand or improve an EMS system. It would be amended to clarify that the application process set forth in the section applies only to contracts for this purpose.

No substantive amendments are proposed to §§1001.25 (relating to technical assistance), 1001.26 (relating to restrictions on contracting), or 1001.27 (relating to subcontracting).

Section 1001.28 (relating to contracts with the Council) would be new. It would be added to clarify that some of the provisions in the subchapter do not apply to Department contracts with the Council. It would also provide that the Department will

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contract with the Council to provide it with the funds the Council needs to perform the duties imposed upon it by the act, and may contract with the Council for it to assist the Department in complying with the provisions of the act. Act 82 amended §14(d) of the Act (35 P.S. §6934(d)) to permit the Department to distribute EMSOF monies to the Council.

Subchapter C. Collection of Data and Information

Section 1001.41 (relating to data and information requirements for ambulance services) addresses an ambulance service's responsibility to complete an ambulance call report and to keep the report confidential. This section would be revised to delete the data elements currently specified. The required data elements are identified in the ambulance call report form and would continue to be so identified. The data elements are revised from time to time by the Department, in consultation with the Council. The data elements currently specified in the regulation are outdated.

Some of the data identifies patient condition and treatment, while other data provides information on how well the EMS system is functioning. The ambulance

service would be required to provide the data solicited by the form, and the form would specify which data is to be handled in a confidential manner. The present regulation treats all data as confidential. "Ambulance call report" would be defined in §1001.2 (relating to definitions) in a manner that would permit the report to be completed by the electronic input of data if permitted by the Department.

This section would also be amended to require certain patient information solicited by the ambulance call report to be reported immediately to a receiving facility, prescribe the time in which an ambulance call report is to be completed after termination of services to the patient, and impose a duty upon an ambulance service to establish a policy prescribing who is to complete the report on behalf of the ambulance service. The ambulance call report would designate the data that is to be reported immediately to the receiving facility.

Section 1001.42 (relating to dissemination of information) identifies the circumstances under which an ambulance call report may be released. This section would be revised to provide that persons who prepare or secure data from an ambulance call report by virtue of their participation in the Statewide EMS system are required to

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prohibit access to only those data elements designated as confidential by the Department in the body of the ambulance call report. There is no need to keep confidential information that does not address the history, assessment, or treatment of the patient.

Subchapter D. Quality Improvement Program

The title of this subchapter would be amended to substitute "Improvement" for "Assurance." The term "quality improvement" has generally replaced "quality assurance" in the health care industry.

This subchapter would be amended to clarify that the quality improvement program operated by the Department and regional EMS councils is to be limited to monitoring and data collection activities. Section 5(b)(10) of the act (35 P.S. §6925(b)(10)) empowers the Department to establish a quality improvement program only for the purpose of "monitoring the delivery of [EMS]." The Department is not empowered to impose patient service duties upon providers of EMS or prehospital personnel under this provision. These clarifications would be made in §1001.61 (relating to components) and §1001.62 (relating to regional programs).

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Sections 1001.63 (relating to medical command facilities) and 1001.64 (relating to ambulance services), which now require medical command facilities and ambulance services to participate in the quality improvement program, would be deleted and replaced with §1001.65 (relating to cooperation). This section would require all persons and entities authorized by the Department to participate in the Statewide EMS system to provide the Department and the regional EMS councils with data and reports requested by them to monitor the delivery of EMS as part of quality improvement oversight.

Subchapter E. Trauma Centers

This subchapter, comprised of §§1001.81-1001.84, was adopted by the Department pursuant to its duty under §5(b)(12) of the act (35 P.S. §6925(b)(12)) to integrate trauma centers into the Statewide EMS system. No substantive amendment would be made to these sections.

Subchapter F. Requirements for Regional EMS Councils and the Council

Section 1001.101 (relating to governing body) specifies standards for the

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governing bodies of the Council and regional EMS councils. It would not be amended.

Sections 1001.102 (relating to council director) and 1001.103 (relating to personnel) would be deleted. These sections specify duties of directors of regional EMS councils and the Council, and written policies and procedures that are to be in place for both. Consistent with Executive Order 1996-1, the Department would repeal these regulations because they are burdensome and do not serve a compelling interest, and because there are viable nonregulatory alternatives that may be pursued to implement these standards if they become necessary. The Department believes that it is counterproductive to micro-manage the Council and the regional EMS councils. If the Department concludes that specific personnel and work policies are required for the Council or a regional EMS council to complete a project, the Department may include those terms in the body of the contract covering the project.

Subchapter G. Additional Requirements for Regional EMS Councils

No substantive change would be made to §§1001.121 (relating to designation of regional EMS councils), 1001.122 (relating to purpose of regional EMS councils) or

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1001.124 (relating to composition). Language would be added to §1001.121 which would require a regional EMS council to be representative of the professions and organizations as prescribed in the statutory definition of "emergency medical services council" in §3 of the act (35 P.S. §6923). Health care consumer representation would also be required.

Section 1001.123 (relating to responsibilities) identifies the major responsibilities of regional EMS councils. The Department concluded that some of the responsibilities are set forth more than once, in slightly different language. The section would be amended to eliminate the repetition. It would also be amended to require regional EMS councils to: notify emergency communications centers and municipal and county governments of available EMS resources and any dispatch recommendations that it or the Department may develop; assist prehospital personnel and providers of EMS operating in the regional EMS system to meet licensure, certification, recertification, recognition, biennial registration and continuing education requirements, as well as assisting the Department in ensuring that those requirements are met; apprise medical command facilities and ALS ambulance services in the region when an EMT-paramedic or prehospital registered nurse loses medical command authorization for an ambulance

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service in the region; and develop a conflict of interest policy applicable to its employees and officials.

Section 1001.125 (relating to requirements) deals with matters such as the composition of the regional EMS council when it is a nongovernmental body, and the composition of its advisory council when it is a governmental body. This section would be amended to require that if a regional EMS council is a unit of local government it shall have an advisory council representative of the professions and organizations designated in the act's definition of "emergency medical services council," as well as health consumer representation, and that if the regional EMS council is a public or nonprofit organization, its governing body shall satisfy the same representation requirements. The current regulatory designation of representatives is somewhat confining and not fully consistent with the statutory language prescribing composition. The Department would replace that language with the composition language contained in the act and consider whether the statutory representation requirements are met on a case by case basis.

This section also requires a regional EMS council to have a medical advisory committee. As "medical advisory committee" is defined in §1001.2 (relating to

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definitions), a majority of its members must be physicians.

Subchapter H. Additional Requirements for the Council

No substantive revisions would be made to this subchapter, comprised of §§1001.141-1001.143.

Subchapter I. Research in Prehospital Care

Section 5(b)(3) and (4) of the act (35 P.S. §6925(b)(3) and (4)) contemplates that the Department will permit data collected through the Statewide EMS system to be used for research to identify possible options for improving the system. The Department's planning responsibilities imply that the Department may authorize research to aid it in making planning decisions. This subchapter addresses the procedures for providers of EMS to engage in clinical investigations or studies that relate to direct patient care in the Statewide EMS system.

Section 1001.161 (relating to research) would be amended to revise the research

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proposal review process to provide for the proposal to be submitted directly to the Department. The regulation would provide for the Department to then forward the proposal to the Council and the appropriate regional EMS council, for review and recommendation back to the Department, if the Department concludes that the proposal may have merit. Upon receiving those recommendations the regulation would prescribe a 30-day time period for the Department to act. The Department intends the time period for action to be directory; that is, its failure to act within that time period would not result in automatic approval of the proposal. Under current procedures, the Department does not see the proposal until after it is reviewed by the Council and a regional EMS council. The regulation would also require the proposal to include a plan for providing the Department with progress reports and a final report, and provide that the Department may terminate the research prematurely if conditions of approval are not satisfied.

Chapter 1003. Personnel

This chapter addresses qualifications and responsibilities of persons involved in the Statewide EMS system. It also addresses the disciplinary process for prehospital personnel certified or recognized by the Department, the medical command authorization

process, continuing education requirements applicable to certain types of prehospital personnel and continuing education options applicable to others, and the accreditation standards for sponsors of continuing education.

Subchapter A. Administrative and Supervisory EMS Personnel

Section 1003.1 (relating to Commonwealth Emergency Medical Director) specifies the duties of the Commonwealth Emergency Medical Director. It would not be revised in a substantive manner.

Section 1003.2 (relating to regional EMS medical director) specifies the duties of regional EMS medical directors. It would be revised to clarify that the regional EMS medical director does not function independent of the regional EMS council except when acting upon appeals from adverse medical command authorization decisions. As the regulation currently reads, it purports to impose upon regional EMS medical directors responsibilities the act imposes upon regional EMS councils. This section would also be amended to exclude a paragraph regarding medical advisory committees. The existing paragraph merely repeats provisions set forth in §1001.125 (c) and (d) (relating to

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requirements).

Section 1003.3 (relating to medical command facility medical director) specifies the qualifications and responsibilities of a medical command facility medical director. It would be amended to require that a physician complete either an APLS (advanced pediatric life support) or a PALS (pediatric advanced life support) course, among other criteria, to qualify as a medical command facility medical director if the physician is not board certified in emergency medicine. Completion of an ACLS (advanced cardiac life support) course would be required every two years to continue to qualify. Completion of an ATLS (advanced trauma life support) course would be required only once. A similar change would be made to §1003.4 (relating to medical command physician). The regulation would also be amended to provide that the physician could satisfy some course requirements specifically mentioned in the regulation by completing other programs determined by the Department to meet or exceed the standards of the specified programs.

Section 1003.4 (relating to medical command physician) specifies the qualifications and responsibilities of a medical command physician. It would be amended to include the same options as mentioned in the prior paragraph. Another amendment

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would be to require a medical command physician to provide medical command whenever it is sought from prehospital personnel. The Department has received complaints from ambulance services that transport initially stable patients over long distances, that when emergencies arise during transport, and communication with a customary medical command physician cannot be established, medical command physicians unfamiliar with the ambulance service and its prehospital personnel will sometimes decline to provide necessary medical command. The amendment would remedy this problem.

To ease the difficulty of working with prehospital personnel with whom a medical command physician is unfamiliar, the regulation would be amended to provide the medical command physician with discretion regarding the treatment protocols to follow. The section would state that in providing medical command to ground ambulances, the medical command physician may follow the transfer and medical treatment protocols that apply either in the EMS region in which treatment originates, or in the EMS region in which the prehospital personnel first receive medical command from the medical command physician.

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Procedures for physicians to secure approval as medical command physicians, which are not now addressed in the regulations, would be explained in this section. There has been a widespread perception that it is the Department's responsibility to approve medical command physicians. This is not technically correct. No provision of the act authorizes the Department to approve medical command physicians. Section 11(f) of the act (35 P.S. §6931(f)) provides that physicians shall be approved as medical command physicians by regional EMS councils, which shall then notify the Department of such approvals. The Department is, however, responsible for prescribing the criteria physicians must satisfy to qualify as medical command physicians. See definition of "medical command" in §3 of the act (35 P.S. §6923). Regional EMS councils are obligated to approve a physician as a medical command physician if the physician meets the prescribed criteria.

The regulation would explain that a physician may seek a determination of medical command physician qualifications directly by a regional EMS council, or may participate in a voluntary medical command physician certification program administered by the Department. If the physician chooses the latter option and receives certification, and demonstrates that he or she will function under the auspices of a medical command

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facility, the regulation would provide that a regional EMS council to which the physician applies for medical command physician approval shall grant the approval.

Functioning under the auspices of a medical command facility is and would continue to be a requirement for approval of a medical command physician by a regional EMS council. The Department prescribes the equipment and personnel requirements for a medical command facility. See definition of "medical command facility" in §3 of the act (35 P.S. §6923). While no provision of the act compels a facility to seek Department approval before operating as a medical command facility, §11(j)(4) of the act (35 P.S. §6931(j)(4)) affords civil immunity for good faith medical commands given to prehospital personnel only if the medical command facility has been "recognized" by the Department.

The Department administers a program for the recognition of medical command facilities. If a physician applies to a regional EMS council for approval as a medical command physician, and the medical command facility for which the physician intends to function has not received a certificate of recognition from the Department, the physician would need to establish to the regional EMS council that the facility meets the criteria for

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a medical command facility prescribed by the Department. However, if the facility has a current certificate of recognition from the Department, the regulation would provide that the regional EMS council shall accept the certificate instead of requiring the physician to prove that the facility meets Department-prescribed standards.

Because medical command physicians may provide medical command to ambulance services operating out of more than one region, and may be providing medical command for patients who cross regional borders, the regulation would also require a medical command facility to give notice to the regional EMS council in each region in which it expects medical command physicians functioning under its auspices will be providing medical command, and to explain the circumstances under which medical command would be given in that region.

No substantive change would be made to §1003.5 (relating to ALS service medical director).

Subchapter B. Prehospital and Other Personnel

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Section 1003.21 (relating to ambulance attendant) would be amended to explain the ambulance attendant's role when staffing an ambulance service and to identify the services an ambulance attendant may perform when serving on an ambulance crew. It would also clarify that notwithstanding the structured role that an ambulance attendant performs when serving as a member of an ambulance's crew, an ambulance attendant may provide BLS services separate from an ambulance service in an emergency, with nonmedical good Samaritan civil liability protection.

The 16 years of age criterion now in the regulation would be removed since the act sets no age requirement for an ambulance attendant. The age requirement for an ambulance attendant is regulated by the child labor laws in the Commonwealth, not the act. The child labor laws prohibit a minor under 16 years of age from serving as an ambulance attendant. See §§2 and 7.3(g) of the Child Labor Law, Act of May 13, 1915, P.L. 286, *as amended*, 35 P.S. §§42 and 48.3.

The Department of Labor and Industry advises that the following requirements apply to persons under 18 years of age who work for a volunteer ambulance service as an ambulance attendant and who have not graduated from high school or been declared by

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the chief school administrator to have achieved their academic potential. They are permitted to receive "on-the-job" training as ambulance attendants only if they have secured employment certificates and are at all times under the constant supervision of an adult ambulance company member. They may not serve as ambulance attendants for more than eight hours in one day, and must be given a half-hour "off duty" lunch break if they are on duty for more than five continuous hours. They may not serve on duty later than 12 a.m. on school nights, nor later than 1 a.m. on Friday or Saturday nights during the school term; however, if they respond to a call prior to the deadline, they may continue to serve during the duration of the response to that call. These requirements may change if the Child Labor Law or regulations adopted pursuant to that law are amended.

This section would also be amended to clarify that the services that an ambulance attendant may provide are governed by the first aid skills taught in an advanced first aid course sponsored by the American Red Cross. As new first aid skills are added to the curriculum, an ambulance attendant's scope of practice would expand if the ambulance attendant has received the necessary training. The Department proposes to publish, at least annually, a list of the advanced first aid skills taught in the most recent advanced

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first aid course sponsored by the American Red Cross.

Provisions would also be added to or incorporated by reference in each section relating to prehospital personnel who perform BLS services exclusively (this section, §1003.22 (relating to first responder) and §1003.23 (relating to EMT)), to permit such personnel to perform specified skills only if authorized to do so by the medical director of the ambulance service. For example, this section would permit an ambulance attendant to use an automated external defibrillator when authorized by the ambulance service medical director. While the act requires an ALS ambulance service to have a medical director, it does not require a BLS ambulance service to have a medical director. Nevertheless, personnel on a BLS ambulance service would not be permitted to perform those few skills which the regulations would condition upon medical director approval unless the BLS ambulance service secures the services of a medical director.

Section 1003.22 (relating to first responder) specifies the qualifications and functions of a first responder. It would include scope of practice and good Samaritan amendments similar, but not identical, to those proposed for §1003.21 (relating to ambulance attendant). The first responder's scope of practice is governed by the BLS

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training a first responder has received in a course the Department has approved for first responder training. At present, that scope of practice is the scope of services embraced by the Emergency Responder course taught by the American Red Cross--which is also the American Red Cross's basic course in advanced first aid--the course establishing the scope of practice for an ambulance attendant. However, a first responder's scope of practice may exceed that of an ambulance attendant if the Department develops or approves courses for first responder training which teach skills in addition to those taught in an advanced first aid course sponsored by the American Red Cross. The Department proposes to publish, at least annually, a list of first responder skills taught in the most recent courses approved by the Department for first responder training.

Unlike an ambulance attendant, who requires no certification from the Department, to function as a first responder an individual must be certified by the Department and then meet recertification requirements every three years. This section would be amended to facilitate entry into the Statewide EMS system of individuals who function or have functioned as first responders in other states, by providing that the Department will accept in lieu of successful completion of the education and tests preapproved by the Department, successful completion of education and tests that led to

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first responder or an equivalent status in another jurisdiction, provided the Department concludes that those education and testing requirements are equal to or greater than those required for certification in this state. Using this criteria, the Department has accepted and would continue to accept, among other examinations, the written and practical skills examinations administered for the emergency responder certification issued by the American Red Cross.

Section 1003.23 (relating to EMT) specifies the qualifications and role of an EMT. It would be amended similar to the manner in which §1003.21 (relating to first responder) would be amended. Provisions relating to EMT instructor certification would be removed. That subject matter would be addressed in new §§1003.23a (relating to EMS instructor certification) and 1011.1 (relating to BLS and ALS training institutes).

Section 1003.23a (relating to EMS instructor certification) would be new. Current provisions for EMT instructor certification would be removed from §1003.22 (relating to EMT) and, with some amendments, would be inserted in this section. There is no statutory mandate for EMS instructor certification. However, the Department offers this certification program to potential instructors to improve the quality of training in

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EMS training institutes.

Section 1003.24 (relating to EMT-paramedic) specifies the qualifications and role of an EMT-paramedic. It would be amended to acknowledge that an EMT-paramedic may provide EMS as a good Samaritan in addition to providing EMS for an ambulance service.

Transition provisions for persons to convert certain certifications to EMT-paramedic certification, which were needed when the regulations were adopted in 1989, would be deleted as they no longer have any relevance.

As the sections relating to first responders and EMTs would be amended to facilitate entry into the Statewide EMS system of individuals who function or have functioned in those capacities in another state, this section would be similarly amended, by providing that the Department will accept in lieu of successful completion of the education and tests preapproved by the Department, successful completion of education and tests that led to EMT-paramedic status in another jurisdiction, provided the Department concludes that those education and testing requirements are equal to or

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greater than those required for certification in this state.

Scope of practice provisions would be revised to accommodate changes in accepted ALS practice by EMT-paramedics without constantly revisiting and amending the regulation to permit the performance of additional skills. To be able to perform those additional services the EMT-paramedic would be required to receive appropriate training either in a course approved by the Department towards securing certification as an EMT-paramedic, in a course determined by the Department to meet or exceed an EMT-paramedic training course preapproved by the Department, or in a Department-approved continuing education course. The Department proposes to publish, at least annually in the *Pennsylvania Bulletin*, a list of EMT-paramedic skills taught in the most recent courses approved by the Department for EMT-paramedic training.

Section 11(d)(2)(vi) of the act (35 P.S. §6931(d)(2)(vi)) provides that if an EMT-paramedic loses medical command authorization, and chooses to function at the BLS level, the EMT-paramedic must secure EMT certification in accordance with Department regulations. The practical effect of this provision is that it requires such an EMT-paramedic to secure continuing education or pass practical skill and written examinations

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every three years, to replace the annual continuing education and skill proficiency requirements that the EMT-paramedic would have been required to satisfy if medical command authorization had been maintained. The Department would amend the regulation to permit the EMT-paramedic to provide BLS services for 30 days without EMT certification, for the ALS ambulance service under which his or her medical command authorization was removed or relinquished, provided that ambulance service's ALS service medical director so authorizes.

Section 1003.25a (relating to health professional physician) would be revised, as some of the preceding sections, to acknowledge that a health professional physician may perform EMS as a medical good Samaritan. It would also be amended to eliminate conditions the section currently specifies for a physician to function as a health professional physician. The act's definition of "health professional" states that a physician qualifies to function in that capacity if the physician has "education and continuing education in [ALS] and prehospital care." 35 P.S. §6923. It does not provide for the Department to certify health professional physicians or to set standards physicians would be required to meet to serve as health professional physicians. Therefore, it is incumbent upon a physician and the ambulance service that uses the physician as a health

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professional to ensure that the physician is properly educated and experienced to serve in that capacity. If they need assistance in making this assessment they may seek guidance from the Department, regional EMS councils, and professional organizations with relevant expertise, such as the Pennsylvania Chapter of the American College of Emergency Physicians.

Section 1003.25b (relating to prehospital registered nurse) specifies the qualifications and role of a prehospital registered nurse. It would be revised to acknowledge that a prehospital registered nurse may perform EMS as a medical good Samaritan, in addition to functioning as a prehospital registered nurse. It would also include endorsement provisions permitting persons who are licensed as registered nurses in this Commonwealth, who have functioned in the capacity of a prehospital registered nurse in another jurisdiction, to obtain recognition as a prehospital registered nurse from the Department through an abbreviated process. It would further be revised to clarify the scope of practice of a prehospital registered nurse by providing that such person could perform those ALS services authorized by The Professional Nursing Law, which exceed the scope of practice of an EMT-paramedic, when authorized by a medical command physician through either direct medical command orders or standing treatment protocols.

CONTINUATION SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU
(Pursuant to Commonwealth Documents Law)

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Section 1003.26 (relating to rescue personnel) pertains to the Department's certification of rescue personnel. It would be amended to clarify that the Department approves courses for rescue personnel and issues certifications to persons who complete those courses. Receipt of such a certification is not, however, required by law as a precondition to freeing an entrapped person. The Department is granted no regulatory oversight over rescue activities under the EMS Act. The Department approves rescue programs and issues rescue technician certificates as a public service, in an effort to ensure that there are a sufficient number of personnel throughout the Commonwealth who have appropriate training and skills to perform rescues. The certification would merely reflect the Department's opinion that the person is qualified to perform the rescues taught in the approved course. The section would be revised to clarify that receiving a rescue certification issued by the Department is not a legal precondition to performing rescues.

No substantive change is being proposed to §1003.27 (relating to disciplinary and corrective action).

Section 1003.28 (relating to medical command authorization) specifies the criteria for an ALS service medical director to grant medical command authorization, and the

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procedures for EMT-paramedics and prehospital registered nurses to appeal ALS service medical director decisions to deny, restrict or remove medical command authorization. It would be amended in several respects. The options available to the ALS service medical director to assess the competence of the ALS practitioner seeking medical command authorization would be expanded.

Also, there would be limitations on how an ALS service medical director could restrict medical command authorization. The Department believes that patient welfare would be compromised if a patient was treated by an ALS practitioner who was not permitted to perform an ALS skill required by the patient and generally permitted under medical command authorization. Consequently, the regulation would be revised to provide that if the ALS practitioner demonstrated certain deficiencies, the ALS service medical director could continue to extend medical command authorization to the individual with restrictions such as requiring the individual to perform certain functions under on-scene supervision. However, short of withdrawing the practitioner's medical command authorization, an ALS service medical director could not preclude the individual from performing functions within that practitioner's scope of practice as permitted by the medical treatment protocols in the region out of which the individual

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practices. Another type of restriction that would be authorized would be to prescribe continuing education requirements greater than that required for other ALS personnel serving the ambulance service. This would require that the ALS service medical director has determined that the individual does not demonstrate sufficient competence in performing a skill and that the number of continuing education hours generally required are not sufficient to provide the education the practitioner needs to remedy the problem.

Other amendments would include a provision stating that in hearings in which medical command authorization decisions are appealed the burden of proof is a preponderance of the evidence, and provisions addressing when service of documents is consummated and how time periods for filing hearing documents are to be calculated in the appeal process.

Section 1003.29 (relating to continuing education requirements) specifies the continuing education requirements and options for prehospital personnel. It would also include several amendments. The total number of continuing education credit hours applicable to each category of certified or recognized prehospital practitioner would not change. However, for each type of practitioner a specified number of continuing

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education hours in medical and trauma education would be designated. Transition periods would be provided before the medical and trauma continuing education requirements would take effect. Also, the Department's existing practice of prorating annual continuing education requirements during the first calendar year an EMT-paramedic is certified or a prehospital registered nurse is recognized, based upon the month the certification or recognition is secured, would be set forth in the regulation.

The options for satisfying continuing education CPR requirements would be expanded. CPR requirements could be met by not only attending a CPR course, but, alternatively, by teaching a CPR course. To secure credit for teaching, the individual would not need to be the primary instructor.

Language would also be added to clarify that an ambulance service is not precluded from imposing continuing education requirements in excess of those required by the regulation, as a condition of employment, except that the ambulance service could not establish individual requirements for ALS practitioners other than as authorized in §1003.28(c)(2) (relating to medical command authorization).

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Current provisions relating to continuing education through endorsement would be relocated in proposed new §1003.31 (relating to credit for continuing education).

Section 1003.30 (relating to accreditation of sponsors of continuing education) would be amended to permit a continuing education sponsor to secure prior approval of continuing education courses, and permit the continuing education sponsor to assign credit hours to a continuing education course it presents in a classroom setting, if the Department gives it approval to do so after determining that it has demonstrated a history of understanding and compliance with the regulatory standards for providing continuing education to prehospital personnel.

Section 1003.31 (relating to credit for continuing education) would be new. It would define what constitutes a credit hour, and time units of instruction for which credit would be awarded. It would also make provision for continuing education credit to be awarded for teaching, self study courses and other courses not presented in a classroom setting, and for courses offered by organizations with

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national or state accreditation to provide education. Additional matters that would be addressed are how continuing education credits would be reported to prehospital personnel, and the procedure for resolving disputes when a prehospital practitioner believes that he or she has not received credit that has been earned.

Section 1003.32 (relating to continuing education sponsors) would also be new. This section would specify responsibilities of a continuing education sponsor with respect to keeping records of attendance, reporting attendance, having a mechanism for course evaluation, retaining records, monitoring compliance, and making available various reports and records to the Department.

Section 1003.33 (relating to advertising) would be another new section. It would address how a continuing education sponsor may advertise a course approved by the Department, as well as a course for which Department approval is being sought, but has not yet been obtained.

Section 1003.34 (relating to withdrawal of accreditation or course approval) would also be new. It would provide for the Department to withdraw

accreditation, downgrade accreditation to provisional status, or withdraw approval of a continuing education course applicable to any future presentation of the course.

The Department would delete subchapter C (relating to air ambulance personnel), and address much of the subject matter of this subchapter in Chapter 1007 (relating to the licensing of air ambulance services-rotorcraft). The Department believes that some of the provisions in this subchapter, such as those in §1003.43 (relating to air ambulance pilot) and §1003.44 (relating to air ambulance communications specialist), exceed the Department's rulemaking authority, since it has been given no authority under the act to regulate either communications specialists or pilots. The more appropriate focus of the Department's regulatory oversight is on the air ambulance service itself.

Also, the provision in §1003.42 (relating to air ambulance crew members), that requires minimum staff in an air ambulance to consist of two ALS prehospital practitioners, is inconsistent with the staffing requirements of §12(g) of the act (35 P.S. §6932(g), which requires an ALS ambulance (no statutory distinction is made

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between air and ground ALS ambulances) to be staffed by two prehospital personnel but only one ALS practitioner when providing treatment and transport to patients. While the Department continues to encourage air ambulance services to staff air ambulances with a minimum of two ALS practitioners, it has no statutory authority to mandate that minimum staffing complement through regulations.

The Department does have statutory authority to regulate air ambulance services to ensure that they operate in a safe and efficient manner. Consequently, many of the responsibilities that have been set forth in subchapter C as responsibilities of individuals such as pilots, medical crew members and communications specialists, would be incorporated in amendments to Chapter 1007 and imposed upon the air ambulance service itself.

Chapter 1005. Licensing of BLS and ALS Ground Ambulance Services

This chapter specifies the licensure and operating criteria for ground ambulance services. The term "ground" would be included in the title to clarify

that the scope of this chapter relates to ground ambulance services exclusively. Chapter 1007 pertains to air ambulance services.

Section 1005.1 (relating to general provisions) would be amended to state that Chapter 1005 applies to ground ambulance services. Subsection (c) would be revised to identify types of ambulance vehicles an ALS ambulance service may employ rather than modes of ALS ambulance service operations.

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Section 1005.2 (relating to applications) would be revised to reflect that there would be a change in some of the information solicited by an application for licensure. The most significant changes are that the application would require that the applicant provide a roster and staffing plan, and identify the physical structures where ambulances will be located or a plan for locating and operating ambulances if not responding out of fixed buildings. Also, the application would require the signature of the principal official of the applicant.

Another change would be that instead of requesting the applicant to identify primary and mutual aid service areas, the application would require the

applicant to identify an emergency service it commits to serve when called upon. An ambulance service that generally confines its operations to interfacility transports would not need to commit to providing emergency response to an area, but, if it had an available ambulance and crew, would be required to respond to an emergency if dispatched.

Mutual aid agreements would continue to be encouraged, but they would not be required for licensure. There are three reasons for this. First, some ambulance services engage almost exclusively in interfacility transports. They have little need for mutual aid arrangements. Second, some ambulance services have attempted to keep competitors from locating in their service areas by refusing to enter into mutual aid agreements with them, and have then argued to the Department that those competitors do not meet required standards for licensure because they have no mutual aid agreement. Third, the Department is proposing to revise its regulations in §1005.10 (e) (relating to licensure and general operating standards) to require ambulance services to contact public safety answering points (PSAPs) when unable to respond to an emergency, instead of the ambulance service making its own arrangement for a substitute ambulance

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service. This should ensure that the most appropriate backup ambulance service is contacted to respond to an emergency, rather than a less appropriate ambulance service that would have been contacted solely to honor a mutual aid agreement.

Subsection (d) would be added to require an ambulance service to file a change of vehicle form within 10 days after placing a new ambulance in operation. If the form would be timely filed, the ambulance service would have authority to continue to use the ambulance unless its authority to do so would be disapproved following Department inspection.

Subsection (e) would require an ambulance service to apply for an amendment of its license prior to substantively altering its plan for locating and operating ambulances. For example, relocating ambulances within the same service area would not be a substantive alteration and would not require an application for amendment. Moving ambulances to establish a new service area would be a substantive alteration and would require an application for an amendment of the license. The Department would need to ensure that all licensure criteria are satisfied at the new or additional location before operations

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could commence.

Amendments that would change the application procedure are that regional EMS councils would no longer be required to forward a complete and accurate application to the Department, and then await Department direction before scheduling an onsite inspection of the applicant. Regional EMS councils, without Department direction, would simply schedule the inspection when the application is complete and appears to be accurate. Also, regional EMS councils would not be required to review the application for conformance with regional plans before they conduct a survey. Actually, they do not do that now even though the regulation states that they are suppose to. Instead, the inspector would review the policies and procedures of the applicant during the survey, and ensure that necessary policies are in place.

Section 1005.3 (relating to right to enter, inspect and obtain records) pertains to an ambulance service's duty to permit employees of the Department or regional EMS councils to conduct inspections, review the applicant's or ambulance service's policies, and secure copies of records from it. It would be

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revised to clarify that the ambulance service has a duty to permit such review and that its failure to do so constitutes misconduct and a basis for discipline.

Section 1005.4 (relating to notification of deficiencies to applicants) pertains to how the Department and the regional EMS council interact with an applicant if there are deficiencies following an on site inspection. It would be revised to relate that the inspector will provide the applicant with an inspection report specifying deficiencies immediately upon completing the inspection. It would further revise procedures for the regional EMS council securing a plan of correction and conducting a reinspection. Finally, it would provide for Department involvement to address disputes upon the request of the applicant.

Section 1005.5 (relating to licensure) identifies the indicia of licensure issued to ambulance service and directs ambulance services where to place those items. This section would be amended to specify changes in some of the information included in the license certificate. Clarification would be provided that the ambulance decal is considered part of the license and is to be placed in a conspicuous place on the outside of the ambulance. The requirement that a

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license be posted in a conspicuous place on the ambulance is set forth in section 12(j) of the act (35 P.S. §6932(j)).

Section 1005.6 (relating to out-of-State providers) recognizes the statutory permission for ambulance services not licensed in this Commonwealth to transport patients from outside the borders of this Commonwealth to facilities situated inside the Commonwealth's borders. The language would be revised, but no material amendment would be made to this section.

Section 1005.7 (relating to services owned and operated by hospitals) parallels provisions in section 12(r) of the act (35 P.S. §6932(r)) which permits institutions licensed as hospitals by the Department to operate their own ambulance service without securing a separate license from the Department to operate an ambulance service. In all other matters the ambulance service operations of hospitals are subject to the requirements of the act and this part. No substantive amendment is proposed to this section.

Section 1005.7a (relating to renewal of ambulance service license) would

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be new. It would explain that the criteria for the renewal of a license is the same as the criteria would be for securing an initial license if an initial license had been sought at the time the renewal was required. A time period for filing a renewal application prior to the expiration of a current license would be specified.

Section 1005.8 (relating to provisional license) pertains to the license the Department is permitted to issue to an ambulance service when it fails to meet multiple minor licensure requirements, or even a significant requirement, if the Department considers the operation of the ambulance service to be in the public interest. Section 12(m) of the act (35 P.S. §6932(m)) permits the Department to issue a provisional license for six months and to renew it for an additional six months pursuant to regulations established by the Department, except a renewal may be for 12 months if the ambulance service is a volunteer BLS ambulance service, or a volunteer fire department or rescue service that operates a BLS ambulance service. The only significant change proposed by the Department is that to secure a renewal of a provisional license the applicant would need to show that it had made a good faith effort to comply with a course of correction approved by the Department.

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Section 1005.9 (relating to temporary license) pertains to the license that the Department is permitted to issue to an ALS ambulance service that cannot provide service 24 hours a day, 7 days a week. Once again, the most significant factor affecting the Department's decision regarding whether to issue a temporary license under these circumstances is whether the issuance of such a license would be in the public's interest. No significant amendment is proposed.

Section 1005.10 (relating to licensure and general operating standards) is the section that enumerates most of the standards an ambulance service needs to meet to become licensed and to continue operations. Compliance with many of the current standards, as well as several of the proposed additional standards, cannot be fully judged until the ambulance service has become licensed and commences operations. The Department proposes to amend the title of the section by including a reference to "general operating standards" to emphasize that the enumerated standards continue to apply after ambulance service licensure.

Additional changes proposed are that the ambulance service would need to maintain documentation of its plan for ensuring that minimum staffing

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requirements are met, a record of calls to which it did not respond and the reasons for not responding, a record of time periods that the ambulance service was not in operation and documentation that appropriate notification was given to relevant PSAPs, and a copy of all policies required by the section.

A BLS ambulance service would be permitted to carry ALS equipment and drugs if it has a medical director who has education and continuing education in ALS prehospital care, provided that such arrangement would be specifically authorized by the Department upon its determination that the arrangement is in the public interest. This has occurred in one remote rural area and may be necessary in others.

A provision of the regulation dealing with who may accompany a patient in the patient compartment, which was inconsistent with language in the act, would be revised to eliminate that inconsistency.

The manner in which ambulance services may meet minimum staffing requirements would be addressed and clarified.

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The Department is not empowered by the act to regulate persons who drive ambulances. However, §12(h)(1) and (4) of the act (35 P.S. §6932(h)(1) and (4)) state that conditions for licensure include that an ambulance service be staffed by responsible people, and that it operate in a safe and efficient manner. Subsection (d)(3) of this section would identify minimum standards a person must meet for the Department to consider a driver to be a "responsible" person. The ambulance service would be required to ensure that each person it permits to drive its ambulances meets these requirements.

Subsection (e) would address an ambulance service's duty to communicate with PSAPs. Community Life Support Systems, Inc., *et al.* v. Department of Health, 689 A.2d 1014 (Pa. Cmwlth. 1997) and Mars Emergency Medical Services, Inc. v. Township of Adams and Borough of Callery, 704 A.2d 1143 (Pa. Cmwlth. 1998), clarify that the Department is not empowered by the act to regulate the dispatching of ambulance services. Nevertheless, as the lead agency for EMS in the Commonwealth, the Department needs to ensure that ambulance services provide information to PSAPs that may influence dispatch decisions. Consequently, the Department is proposing to require an ambulance service to

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give a PSAP in its area advance notice when it will not be in operation, and to communicate with and provide information to PSAPs as they request to aid them in implementing dispatch protocols.

The responsibility to communicate would continue after an ambulance service receives a call and then determines that it is unable to mobilize its resources to respond to an emergency. These communications from ambulance services will enable the PSAPs to timely contact and dispatch other available EMS providers when the public interest so warrants.

Finally, this portion of the regulation would require ambulance services to respond to calls for emergency assistance as communicated by the PSAPs. Unfortunately, the Department has received reports of ambulance services arguing with each other as to which of them has the right to treat and transport a patient. Financial considerations cannot be permitted to undermine or delay patient care. While there may be some dispute between municipalities, counties and PSAPs as to who has the authority to resolve which ambulance service among two or more similarly licensed ambulance services is best suited to provide care to a patient on

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a case by case basis, the PSAP is the entity through which ambulance service receives the dispatch communication. The Department believes that an orderly Statewide EMS system is best achieved when ambulance services follow the dispatch directions communicated by PSAPs, regardless of the entity empowered to determine the dispatch protocol.

The Department would also revise the subsection (g) requirements pertaining to the use of lights and other warning devices by providing that an ambulance service may use such devices only when transporting or responding to a call involving a patient who presents or is in good faith perceived to present a combination of circumstances resulting in a need for immediate medical intervention. Driving an ambulance at rapid speeds, even when alerting pedestrians and drivers of other vehicles through the use of warning devices, creates a dangerous situation. That danger should be avoided unless compelling circumstances dictate otherwise.

The subsection (f) provisions relating to scene control would be replaced by provisions addressing who may manage patient care at the scene of the

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emergency and in the ambulance.

The Department also proposes to impose upon an ambulance service a duty to report to a regional EMS council an accident, injury or fatality involving an ambulance vehicle or a member of an ambulance crew while performing functions on duty. This information will be examined and evaluated in considering how to better protect ambulance personnel and the public during ambulance service operations.

Additional responsibilities that would be imposed would be for an ALS ambulance service to apprise an appropriate regional EMS council as to who has medical command authorization for that ambulance service, and any change in that status, and for an ambulance service to monitor compliance with all requirements the act and the regulations impose upon the ambulance service and its staff.

Section 1005.11 (relating to drug use, control and security) would be amended to better clarify the circumstances under which ambulance services may

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stock and carry drugs, and would address which drugs may be used, requirements for securing and maintaining those drugs, and who may administer such drugs. Some of the most significant proposals deal with drugs being brought upon a BLS ambulance by ALS personnel when those personnel rendezvous with a BLS ambulance to treat an ALS patient, circumstances under which health professionals may bring drugs upon an ambulance and use those drugs upon patients other than as authorized by the applicable regional transfer and medical treatment protocols, and continuation of hospital ordered medication on an ambulance by a nurse, physician or physician assistant when the ambulance is involved in an interfacility transport.

Section 1005.12 (relating to disciplinary and corrective actions) pertains to the disciplinary process applicable to ambulance services. The title of the section would be changed from "Grounds for suspension, revocation or refusal of an ambulance service license" because the scope of this section exceeds the enumeration of grounds for discipline. The most significant amendments proposed would be to add as a basis for discipline not communicating with PSAPs as would be prescribed in §1005.10(e) (relating to licensure and general operating

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standards), and revising how the Department would communicate with ambulance services and complainants during and upon completion of complaint investigations.

Section 1005.13 (relating to removal of ambulances from operation) pertains to the removal of an ambulance from operation when there is a mechanical or equipment deficiency that poses a significant threat to the safety of patients or crew. No substantive amendment is being proposed.

Section 1005.14 (relating to invalid coaches) pertains to a statutory exemption from ambulance requirements for vehicles that are used to transport individuals who require assistance, but who are not anticipated to require emergency medical care during transport. No amendment is being proposed.

Section 1005.15 (relating to discontinuance of service) would be new. This section would address and clarify the duty imposed upon an ambulance service, by section 12(q) of the act (35 P.S. §6932(q)), to not discontinue its operations prior to giving the public, the Department and political subdivisions in

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its service area at least 90 days advance notice. The regulation would also require the ambulance service to provide similar notice to emergency communications centers in the EMS region in which it would be ceasing operations.

Chapter 1007. Licensing of Air Ambulance Services-Rotorcraft

This chapter specifies the licensure and operating criteria for air ambulance services. Several sections in Chapter 1005 (relating to licensing of BLS and ALS ground ambulance services), that would be applicable to ground ambulance services, would be equally applicable to air ambulance services. Express provision would be made in this chapter to incorporate applicable provisions in Chapter 1005. Consequently, some of the current sections in this chapter would not be needed. The unnecessary provisions would be repealed.

As a preliminary matter, the Department received comments during the process of developing proposed amendments that the regulations should be extended to entities that operate fixed-wing aircraft that provide medical treatment and transport of patients. The Department is considering the recommendation, but

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is not prepared to propose regulations regulating such entities at this time.

Section 1007.1 (relating to general provisions) specifies general standards applicable to air ambulance services. The most significant amendment of this regulation would be the addition of a subsection (e). That subsection would specify the sections in Chapter 1005 (relating to licensing of BLS and ALS ground ambulance services) that would apply to air ambulance services as well as ground ambulance services. These would include §§1005.3 (relating to right to enter, inspect and obtain records), 1005.4 (relating to notification of deficiencies to applicants), 1005.5 (relating to licensure), 1005.7a (relating to renewal of ambulance service license), 1005.8 (relating to provisional license), 1005.9 (relating to temporary license), 1005.11 (relating to drug use, control and security), 1005.13 (relating to removal of ambulances from operation), and 1005.15 (relating to discontinuation of service).

All air ambulance services are licensed to provide ALS care. Some of the sections that would be referenced in subsection (e) would impose different requirements upon a ground ambulance service depending upon whether the

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service was licensed to provide ALS care or only BLS care. This subsection would clarify that the provisions of those sections which would apply to air ambulance services are those which would apply to ground ALS ambulance services.

Section 1007.2 (relating to applications) specifies the information solicited by applications for air ambulance service licenses. It would be amended to identify changes in some of the information that would be solicited. The section would also be amended to direct the applicant to file the license application with the regional EMS council having responsibility for the region in which the applicant intends to station its air ambulances, and it would prescribe how the application is to be processed by the regional EMS council. The section would further be amended to include a subsection identifying changes in the operations of the air ambulance service which would require a license amendment.

Section 1007.3 (relating to licenses) would be repealed. This section addresses matters such as the Department procedures for reviewing air ambulance license applications and display of the license. Some of the procedures would be

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revised, as set forth in §1007.2 (relating to applications). Other matters would be addressed in §1005.5 (relating to licensure). Section 1007.1(e) (relating to general provisions) would make §1005.5 applicable to air ambulance services.

Section 1007.4 (relating to renewal of air ambulance license) would be repealed. This section addresses various procedures to be followed for the renewal of an air ambulance service license. This subject matter would be addressed in §1005.7a (relating to renewal of ambulance service license). Section 1007.1(e) (relating to general provisions) would make §1005.7a applicable to air ambulance services.

Section 1007.5 (relating to inspections) would be repealed. This section deals with the authority of Department employees and agents to conduct inspections and investigations of air ambulance services. This subject matter would be addressed in §1005.3 (relating to right to enter, inspect and obtain records). Section 1007.1(e) (relating to general provisions) would make §1005.3 applicable to air ambulance services.

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Section 1007.6 (relating to notification of deficiencies) would be repealed. This section deals with the process for addressing deficiencies following an inspection of an air ambulance service. This subject matter would be addressed in §1005.4 (relating to notification of deficiencies to applicants). Section 1007.1(e) (relating to general provisions) would make §1005.4 applicable to air ambulance services.

Section 1007.7 (relating to licensure and general operating standards) enumerates most of the standards an ambulance service needs to meet to become licensed and to continue operations. The fact that these are ongoing requirements was not conveyed by the title "Licensure requirements." Consequently, the Department proposes to amend the title by adding the language "general operating" to also modify "requirements." Moreover, compliance with many of the current standards, as well as several of the proposed additional standards, cannot be fully judged until the ambulance service has become licensed and commences operations.

Many of the matters addressed in proposed amendments to the

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corresponding section pertaining to ground ambulance services, §1005.10 (relating to licensure and general operating standards), are also addressed in proposed amendments to this section, such as requirements of the air ambulance service to maintain documentation of its staffing plan, a record of calls to which it did not respond and the reason for not responding, and a copy of policies required by the section. Other similar subject matter addressed in the proposed amendments to this section are what constitutes meeting minimum staffing requirements; responsibilities with respect to communicating with PSAPs; medical command notification responsibilities; monitoring responsibilities; and the duty to maintain written policies and procedures.

A significant change is proposed with respect to the personnel required to meet minimum staffing requirements. The current regulations require that at least one of the crew members be a physician or a nurse. This requirement would be deleted. The staffing requirements would be revised to be the same as that required for a ground ALS ambulance service. This change is required as a matter of law. Section 12(g) of the act (35 P.S. §6932(g)) dictates the minimum staff that may be required, for licensure purposes, when responding to calls to provide EMS

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to patients requiring ALS care. The statute makes no distinction between air and ground ALS ambulance services in this regard. The Department has no authority to mandate an air ambulance service to exceed the staffing standards enumerated in 35 P.S. §6932(g). Of course, an air ambulance service is free to exceed the minimum staffing standards prescribed by statute, and should do so if providing proper care to patients requires it to exceed those standards.

Section 1007.8 (relating to disciplinary and corrective actions) deals with the disciplinary process applicable to air ambulance services. The amendments proposed to this section are virtually the same as those proposed to the counterpart section pertaining to ground ambulance services, §1005.12 (relating to disciplinary and corrective actions).

Section 1007.9 (relating to voluntary discontinuation of service) would be repealed. This section addresses the duty imposed upon an air ambulance service, pursuant to §12(q) of the act (35 P.S. §6932(q)), to not discontinue its operations prior to giving advance notice to the Department, political subdivisions in its service area, and the public. This subject matter would be addressed in §1005.15

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(relating to discontinuance of service). Section 1007.1(e) (relating to general provisions) would make §1005.15 applicable to air ambulance services.

Chapter 1009. Medical Command Facilities

This chapter deals with the distinct units in hospitals out of which physicians who qualify as medical command physicians provide medical direction to prehospital personnel when they are providing emergency medical care in prehospital settings and during the interfacility transport of patients.

Section 1009.1 (relating to operational criteria) sets forth the requirements that must be met for a distinct unit in a hospital to function as a medical command facility. The title would be changed from "Accreditation and operational criteria." The reason for deleting the reference to "accreditation" is that the act neither requires nor makes provision for the Department to accredit medical command facilities. However, the definition of "medical command facility" in §3 of the act (35 P.S. §6923), which states that a medical command facility is a distinct unit in a hospital "that contains the necessary equipment and personnel for providing

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medical command to and control to an ambulance service," when combined with other provisions of the act which declare that the Department shall serve as the lead agency for EMS in the Commonwealth (35 P.S. §6925(b)) and shall have the authority to promulgate regulations necessary to carry out the provisions of the act (35 P.S. §6937.1), implies that the Department shall prescribe the "necessary equipment and personnel" for a medical command facility. Some of the more significant amendments proposed to the section are that the medical command facility apprise PSAPs when it is unable to provide medical command, that it have a plan to ensure the availability of medical command in mass casualty situations, and that it provide medical command to prehospital personnel whenever they seek direction.

Section 1009.2 (relating to recognition process) describes the procedure to be followed if a facility chooses to be recognized as a medical command facility by the Department. The title of the section would be changed from "Accreditation process." The reason for the proposed change is that the act does not provide for the accreditation of medical command facilities, but does offer them some degree of protection from civil liability if they are "recognized" by the Department.

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Section 11(j)(4) of the act (35 P.S. §6931(j)(4)) provides that a medical command facility that is recognized by the Department shall not be liable for any civil damages resulting as a consequence of orders issued through it, unless guilty of gross or willful negligence. Conditioning this civil liability protection upon being "recognized" by the Department suggests that medical command facilities may operate without such recognition, but would have greater exposure to civil liability if they choose to do so.

This section would be completely rewritten to explain that securing Department recognition reduces a medical command facility's exposure to civil liability. It would also explain the role of the Department and regional EMS councils in the recognition process and the appeal rights of applicants which are denied medical command facility recognition, and it would provide for medical command facility recognition to have a three-year term.

Section 1009.3 (relating to continuity of medical command) would be repealed. This regulation grandfathered medical command facilities recognized by regional EMS councils prior to July 1, 1989, the date the regulation was

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promulgated. The regulation is no longer required.

Section 1009.4 (relating to withdrawal of medical command facility recognition) identifies the procedures for conducting inspections and investigating complaints against medical command facilities, the grounds for withdrawal of recognition, and procedures for dealing with deficiencies in lieu of withdrawing recognition. The title of the section would be changed from "Suspension/revocation of accreditation."

Section 1009.5 (relating to review of medical command facilities) provides for regional EMS councils to conduct biennial reviews of medical command facilities. This section would be amended to permit the Department more flexibility in determining the frequency of reviews. Comprehensive reviews conducted biennially could impose an excessive work burden on some regional EMS councils, while other regional EMS councils could conduct such reviews more frequently. This is because there are many medical command facilities in some EMS regions, and very few in others. The Department anticipates requesting reviews more frequently than once every two years, but would modify

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the scope of some reviews so that they would not involve a comprehensive assessment of compliance with all recognition criteria. The title of the section would be changed from "Biennial review of facilities."

Section 1009.6 (relating to discontinuance of service) would be new. This section would require a medical command facility to provide the Department, the appropriate regional EMS council, and providers of EMS for which they routinely medical command, with 60 days notice prior to discontinuing medical command operations.

Chapter 1011. Accreditation of Training Institutes

This chapter pertains to the Department's accreditation of teaching institutes that provide persons with the training required by the Department's regulations to become certified as a first responder, an EMT or an EMT-paramedic, or recognized as a prehospital registered nurse. Matters addressed are the criteria for accreditation, the process to secure accreditation, and the process for denying, withdrawing, or conditioning accreditation.

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Section 1011.1 (relating to BLS and ALS training institutes) identifies the criteria to operate as a BLS training institute to provide training leading to certification as a first responder or an EMT, and as an ALS training institute to provide training leading to certification as an EMT-paramedic or a prehospital registered nurse. This section is currently titled "BLS training institutes" and deals only with facilities that provide training leading to certification as a first responder or an EMT. Section 1011.2 (relating to ALS training institutes) addresses only the criteria for providing training leading to certification as an EMT-paramedic or recognition as a prehospital registered nurse. The Department concluded that there was a significant amount of duplication in the two sections. It is therefore proposing that the two sections be consolidated into one. Section 1011.2 would be repealed due to the proposed consolidation of the two sections.

Section 1011.3 (relating to accreditation process) identifies the process for an entity to become accredited as a BLS or ALS training institute. The Department proposes to remove provisions relating to hearings when accreditation is denied, and to consolidate them with other hearing provisions in §1011.4 (relating to denial, restriction or withdrawal of accreditation). The Department

also proposes to delete language providing for the automatic accreditation of a training institute accredited by the American Medical Association. Of course, such an institute would still be accredited if it would meet the minimum standards imposed by this section. The provision proposed for deletion would be replaced by a language providing that if the Department reviews the accreditation standards of another accrediting body, and concludes that they are equal to or greater than the accreditation standards of the Department, the Department could rely upon the accreditation of that accrediting body to abbreviate the Department's own accreditation review.

Section 1011.4 (relating to denial, restriction or withdrawal of accreditation) identifies the procedures for investigating complaints against EMS training institutes, for denying, withdrawing or conditioning accreditation, and for appealing those decisions. The title of the section would be changed from "Suspension/revocation."

Chapter 1013. Special Event EMS

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This chapter enable entities to have a Department determination as to whether EMS arrangements are adequate when those entities are responsible for the management and administration of a planned and organized activity that places attendees or participants in a defined geographic area where access by emergency vehicles might be delayed due to people or traffic congestion at or near the event.

Section 1013.1 (relating to special event planning requirements) would be amended to clarify that submitting a special event EMS plan to the Department for its approval is not mandated under the act. Nevertheless, as the Commonwealth's lead agency for EMS, the Department believes that this is a public service it should make available to entities desiring such a review. Municipalities may also choose to mandate such a review for special events held within their borders. This section would also be amended to reflect that special event EMS plans are to be processed through the regional EMS council assigned responsibility for the region in which the event is to take place. An additional substantive requirement for plan approval would be that it identify measures that have and would be taken to coordinate EMS for the special event with local EMS and public safety

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agencies, such as ambulance, police, fire, rescue, and hospital agencies or organizations.

Section 1013.2 (relating to administration, management and medical direction requirements) would be amended by requiring that a medical command physician provide direction and supervision for the EMS system for it to secure Department approval for a special event involving more than 25,000 people.

Sections 1013.3 (relating to special event personnel and capability requirements), 1013.4 (relating to ALS services requirements), 1013.5 (relating to onsite faculty requirements), 1013.6 (relating to communications systems requirements) and 1013.7 (relating to requirements for educating event attendees regarding access to EMS) would not be amended, except that population figures triggering the application of certain standards in §§1013.3 and 1013.5 would be adjusted downward by 5,000, and equipment requirements in §1013.5 would not be confined to BLS equipment.

Section 1013.8 (relating to special event report) would be new. It would

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require an entity that secured Department approval of a special event EMS plan to file with the appropriate regional EMS council, after concluding a special event, a special event report containing information solicited by the Department in the report form.

Chapter 1015. Quick Response Service Recognition Program

This chapter addresses the mobilization of prehospital personnel to arrive at the scene of emergency and provide EMS in advance of the arrival of an ambulance and its crew. While most areas of the Commonwealth can be reached by an ambulance within a few minutes, there are a few areas, generally rural or remote wilderness areas, where this is not the case. In those areas, the Department, the regional EMS councils, and municipal organizations have attempted to form units of prehospital personnel to respond to emergencies prior to the arrival of an ambulance. The label the Department has given to such an early EMS response team is "quick response service (QRS)."

A shortcoming of the act is that it does not directly provide for the creation

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or regulation of these quick response teams. While statutory criteria exists for granting licenses and pursuing disciplinary and corrective action against ambulance services, no similar provisions exist relative to the organization of prehospital personnel into early response teams.

Nevertheless, the act contemplates that prehospital personnel arriving at an emergency scene by ambulance, and transporting patients by ambulance, are not to be the exclusive components of prehospital EMS. For example, §4(4)(i) and (ii) of the act (35 P.S. §6924(4)(i) and (ii)) direct the Department to coordinate programs to ensure that the Commonwealth's EMS system has an adequate number of vehicles, in addition to ambulances, to transport patients, and that those vehicles be properly staffed and equipped. Also, in 1994 the act was amended by Act 82 to provide for the certification of first responders, which the act describes as persons certified to stabilize and improve a patient's condition in a prehospital setting until more highly trained prehospital personnel arrive at the scene. See §11(a.1) of the act (35 P.S. §6931(a.1)). This chapter is designed to bring first responders and other authorized personnel who provide preambulance medical assistance to patients into the Commonwealth's EMS system in a more structured

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manner than has been accomplished by existing regulations.

Section 1015.1 (relating to quick response service) would be new. It would establish criteria for recognition as a QRS, the process for securing such recognition, and provide for renewal. To receive QRS recognition an applicant would have to maintain equipment that the Department will identify in the *Pennsylvania Bulletin*, have the capability to be dispatched and to communicate with a responding ambulance service, provide EMS only through prehospital personnel and other persons authorized by law to provide such services, provide designated information on an ambulance call report for each call to which it responds, and follow Statewide and regional medical treatment protocols.

Section 1015.2 (relating to discontinuation of service) would be new. It would require a QRS. to provide advance notice to the Department, the appropriate regional EMS council, and each political subdivision within its service area before discontinuing services.

FISCAL IMPACT

CONTINUATION SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU
(Pursuant to Commonwealth Documents Law)

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The cost to the Department to administer and monitor the continuing education program would increase because an additional staff position would be required in the Department to coordinate the integration of revised continuing education standards. Additionally, the Department would incur costs in developing review processes to incorporate alternative methods of course presentation which would be permitted by the amendments. Also, all currently approved continuing education courses (approximately 700) would need to be re-evaluated and assigned new course numbers to reflect trauma and medical continuing education credit hours for which the course would qualify. The Department would also need to revise the reporting and recordkeeping process for it to process continuing education information. Revision of forms and printing would result in associated costs. One computer work system for the additional staff person would be needed.

The Department would also incur additional costs for the continuing education program to update computer software to maintain a registry of continuing education courses. Also, costs would be incurred in updating

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continuing education data processing capabilities. The total estimated costs for these expenditures are $100,500 for FY 1998-99.

Currently, physicians who are not board certified in emergency medicine must complete additional courses to maintain recognition as a medical command physician. Such a physician is required to renew ATLS and ACLS certification on a four-year and two-year basis. Of the 3,200 medical command physicians, approximately 23% (736) of them are board certified in emergency medicine and, therefore, are not required to take additional courses. The regulations for other medical command physicians would be revised to require completion of an ATLS course on a one time basis only. Costs for ATLS courses may range from $125 - $325. Also, these courses are not readily available in rural areas of the Commonwealth. Physicians frequently need to travel to distant parts of the State to complete ATLS courses. The regulations would result in a cost reduction to that physician population ranging from $308,000 - $800,800 every four years.

PAPERWORK REQUIREMENTS

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Medical command facility medical director and medical command physician applications would be revised. The manual the Department distributes to facilities to aid them in meeting medical command facility criteria would need to be revised, reprinted and distributed. The Department would need to do likewise for the manual it distributes to regional EMS councils to aid them in surveying license applicants.

The Department's records for the existing 700 continuing education courses would need to be revised to reflect new course numbers given to them to reflect trauma and medical continuing education credit hours assigned to them. Course forms would need to be revised by institutions offering the courses. They would also incur revised reporting and recordkeeping responsibilities.

In making the transition to the new regulatory standards, the Department intends to employ all opportunity afforded by technology to reduce paperwork and costs.

EFFECTIVE DATE/SUNSET DATE

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The regulations will go into effect when published in the *Pennsylvania Bulletin* as final regulations. No sunset date will be imposed. The Department will monitor the regulations to ensure that they meet EMS needs within the scope of the Department's authority to address through regulations.

STATUTORY AUTHORITY

Section 17.1 of the act (35 P.S. §6937.1) provides that the Department, in consultation with the Council, may promulgate regulations as may be necessary to carry out the provisions of the act. Other sections of the act contain more narrow grants of authority to the Department to promulgate regulations.

In section 3 of the act (35 P.S. §6923), the definitions of "advanced life support service medical director" and "Commonwealth Emergency Medical Director" provide that to qualify as either, one must be a medical command physician or meet equivalent qualifications as established by the Department through regulation. In the same section, the definitions of "emergency medical

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technician" and "emergency medical technician-paramedic" provide that both are to be certified in accordance with the current national standard curriculum as set forth in the regulations of the Department. See, also, Section 11(b)(1)(i) and (d)(1)(i) of the act (35 P.S. §6931(b)(1)(i) and(d)(1)(i)). The definition of "medical command" in section 3 of the act provides that medical command physicians are to meet qualifications prescribed by the Department.

Section 5(2) of the act (35 P.S. §6925(2)) authorizes the Department to employ regulations to establish standards and criteria governing the award and administration of contracts under the act. Section 5(11) of the act (35 P.S. §6925(11)) authorizes the Department to adopt regulations to establish standards and criteria for EMS systems.

Section 11(a)(1) of the act (35 P.S. §6931(a)(1)) provides that the Department shall employ regulations to develop standards for the accreditation of educational institutes for EMS personnel. Section 11(a)(4), (d)(3) and (e) of the act (35 P.S. §6931(a)(4), (d)(3) and (e)) provide that EMT and EMT-paramedics may, in the case of an emergency, perform duties deemed appropriate by the

Department in accordance with the Department's regulations. Section 11(d)(2)(ii)(A) and (B), and (e.1)(3)(i) and (ii)) of the act (35 P.S. §6931(d)(2)(ii)(A) and (B), and (e.1)(3)(i) and (ii)) provide that ALS service medical directors shall base a decision on whether to grant medical command authorization to an EMT-paramedic or prehospital registered nurse upon the individual's demonstrated competency in knowledge and skills as defined by Department regulation and the individual's completion of continuing education requirements adopted by regulation. Section 11(d)(2)(vi) and (e.1)(5) of the act (35 P.S. §6931(d)(2)(vi) and (e.1)(5)) provide that when an EMT-paramedic or prehospital registered nurse chooses to not seek or maintain medical command authorization, and to function exclusively as an EMT, that person is to apply to the Department for recognition as an EMT pursuant to Department regulations. Section 11(f) of the act (35 P.S. §6931(f)) provides that physicians approved by regional EMS councils as medical command physicians may give medical commands subject to Department regulatory requirements. Section 11(h) and (i) of the act (35 P.S. §6931(h) and (i)) provide that regional EMS council transfer and medical treatment protocols are to be established pursuant to Department regulation. Section 11(j)(2) of the act (35 P.S. §6931(j)(2)) grants immunity, for

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specified conduct, to EMS students enrolled in approved courses and supervised pursuant to Department regulations.

Section 12(b) of the act (35 P.S. §6932(b)) provides that applications for the renewal of ambulance service licenses shall be made on forms prescribed by the Department in accordance with its regulations. Section 12(d) of the act (35 P.S. §6932(d)) provides that the Department shall promulgate regulations setting forth minimum essential equipment for BLS and ALS ambulances, as well as design criteria for ambulances.

Section 14(d) of the act (35 P.S. §6934(d)) provides that the standards the Department employs to disburse monies from EMSOF to providers of EMS shall be pursuant to regulation.

REGULATORY REVIEW

Under Section 5(a) of the Regulatory Review Act, the Act of June 30, 1989 (P.L. 73, No. 19) (71 P.S. §§745.1-745.15), the Department submitted a

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copy of these proposed regulations on January 29, 1999 to the Independent Regulatory Review Commission (IRRC) and the Chairpersons of the House Health and Human Services Committee and the Senate Public Health and Welfare Committee. In addition to submitting the regulations, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

If IRRC has any objection to any portion of the proposed regulations, it will notify the Department by April 14, 1999. Such notification shall specify the regulatory review criteria which have not been met by that portion. The Regulatory Review Act specifies detailed procedures for review prior to final publication of the regulations, by the Department, the General Assembly and the Governor of objections raised.

CONTACT PERSON

CONTINUATION SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU
(Pursuant to Commonwealth Documents Law)

Interested persons are invited to submit comments, suggestions or objections regarding the proposal to Margaret E. Trimble, Director, Emergency Medical Services Office, Department of Health, 1027 Health and Welfare Building, P.O. Box 90, Harrisburg, PA 17108, (717) 787-8740, within 30 days after publication of this notice in the *Pennsylvania Bulletin*. If you are a person with a disability, your comments, suggestions or objections may also be submitted to Ms. Trimble in alternative formats, such as by audio tape, braille, or by using TDD: (717) 783-6514. If you are a person with a disability and require an alternate format of this document (e.g., large print, audio tape, braille) please contact Ms. Trimble so that she may make the necessary arrangements.

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ANNEX A

Title 28. Health and Safety

Chapters 1001 -- 1013. Emergency Medical Services

PART VII. EMERGENCY MEDICAL SERVICES

Chap.		Sec.
1001.	ADMINISTRATION OF THE EMS SYSTEM	1001.1
1003.	PERSONNEL	1003.1
1005.	LICENSING OF BLS AND ALS GROUND AMBULANCE SERVICES	1005.1
1007.	LICENSING OF AIR AMBULANCE SERVICES-ROTORCRAFT	1007.1
1009.	[EMS] MEDICAL COMMAND [MEDICAL] FACILITIES	1009.1
1011.	ACCREDITATION OF TRA[D]INING INSTITUTES	1011.1
1013.	SPECIAL EVENT EMS	1013.1
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CHAPTER 1001. ADMINISTRATION OF THE EMS SYSTEM

Subch.		Sec.
A.	GENERAL PROVISIONS	1001.1
B.	AWARD AND ADMINISTRATION OF [CONTRACTS] FUNDING	1001.21
C.	COLLECTION OF DATA AND INFORMATION	1001.41
D.	QUALITY [ASSURANCE] IMPROVEMENT PROGRAM	1001.61
E.	TRAUMA CENTERS	1001.81
F.	REQUIREMENTS FOR REGIONAL EMS COUNCILS AND THE COUNCIL	1001.101
G.	ADDITIONAL REQUIREMENTS FOR REGIONAL EMS COUNCILS	1001.121
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Subchapter A. GENERAL PROVISIONS

GENERAL INFORMATION

Sec.
1001.1. Purpose.
1001.2. Definitions.
1001.3. Applicability.
1001.4. Exceptions.
1001.5. Investigation.
1001.6. Comprehensive EMS development plan.
1001.7. Comprehensive regional EMS development plan.

GENERAL INFORMATION

§1001.1. Purpose.

The [Department has the duty under the act] purpose of this part is to plan, guide, assist and coordinate the development of regional EMS systems into a unified Statewide system and to coordinate the system with similar systems in neighboring states, and to otherwise implement the Department's responsibilities under the act consistent with the Department's rulemaking authority. [The Department will accomplish this purpose through this part.]

§1001.2. Definitions.

The following words and terms, when used in this part, have the following meanings, unless the context clearly indicates otherwise:

ACLS course -- Advanced cardiac life support course -- A course in advanced cardiac life support sanctioned by the American Heart Association.

ALS ambulance service-Advanced life support ambulance service -- An entity licensed by the Department to provide ALS services [and transportation] by ambulance to seriously ill or injured patients. The term includes mobile ALS ambulance services that may or may not transport patients.

ALS service medical director -- Advanced life support service medical director

-- A medical command physician or a physician meeting the equivalent qualifications set forth in §1003.5 (relating to ALS service medical director) who is employed by, contracts with or volunteers with, either directly, or through an intermediary, an ALS ambulance service to make medical command authorization decisions, provide medical guidance and advice to the ALS ambulance service, and [to] evaluate the quality of patient care provided by the prehospital personnel utilized by the ALS ambulance service.

ALS services -- Advanced life support services -- The advanced prehospital and interhospital emergency medical care of serious illness or injury by appropriately trained health professionals and [certified] EMT-paramedics.

APLS course-- Advanced pediatric life support course -- A course in advanced pediatric life support sanctioned by the American Academy of Pediatrics and the American College of Emergency Physicians.

ATLS course -- Advanced trauma life support course -- A course in advanced trauma life support sanctioned by the American College of Surgeons Committee on Trauma.

Act -- The Emergency Medical Services Act (35 P.S. §§6921 -- 6938).

Air ambulance -- A rotorcraft [licensed by the Department for use as an EMS vehicle] specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to, and air transportation of, patients.

[Air ambulance medical crew member -- A licensed physician, registered nurse or certified EMT-paramedic, who meets the qualifications required by Chapter 1007 (relating to licensing of air ambulance services--rotorcraft) and who is employed to provide prehospital medical care and services to patients transported by air ambulance.]

Air ambulance medical director -- A medical command physician or a physician meeting the minimum qualifications set forth in [§1003.41 (relating to air ambulance medical director)] §1003.5 (relating to ALS service medical director) who is employed by, or contracts with, or volunteers with, either directly,

or through an intermediary, an air ambulance service to make medical command authorization decisions, provide medical guidance and advice to the [ALS] air ambulance service, and [to] evaluate the quality of patient care provided by the prehospital personnel utilized by the air ambulance service.

Air ambulance service -- An agency or entity licensed by the Department to provide transportation and ALS care of patients by air ambulance.

Aircraft operator -- The person, company or agency, certified by the FAA, under 14 CFR Part 135 (relating to air taxi operators and commercial operators), to conduct air taxi operations.

Ambulance -- A vehicle specifically designed, constructed or modified and equipped, used or intended to be used, and maintained or operated for the purpose of providing emergency medical care to patients, and the transportation of[,] patients if used for that purpose. The term includes ALS or BLS vehicles that may or may not transport patients.

Ambulance attendant -- An individual who [holds a valid certificate evidencing the successful completion of a course in advanced first aid sponsored by the American Red Cross and a valid certificate evidencing the successful completion of a course in CPR sponsored by the American Heart Association or the American Red Cross, or an individual who can evidence the successful completion of an equivalent training program approved by the Department] possesses the qualifications in §1003.21(b) (relating to ambulance attendant).

Ambulance call report -- A summary of an emergency ambulance response, nonemergency ALS response, interfacility transport, or nonemergency BLS transport that becomes an emergency. The report shall contain information specified in a format provided by the Department.

Ambulance identification number -- A number issued by the Department to each ambulance operated by an ambulance service.

Ambulance service -- An entity which regularly engages in the business or service of providing emergency medical care and transportation of patients in this Commonwealth. The term includes [mobile] ALS ambulance services that

may or may not transport patients.

Ambulance service affiliate number -- [The] A unique number assigned by the Department to an ambulance service, the first two digits of which designate the county in which the ambulances of the ambulance service are based.

[*Ambulance trip report number* -- A unique number assigned to an ambulance response and recorded on the ambulance trip report form.]

BLS ambulance service -- Basic life support ambulance service -- An entity licensed by the Department to provide BLS services and transportation by ambulance to [seriously ill or injured] patients.

BLS services--Basic life support services -- The basic prehospital or interhospital emergency medical care and management of illness or injury performed by specially trained, [and] certified or licensed personnel.

[*BLS training institute -- Basic life support training institute* -- An entity accredited by the Department to conduct BLS training courses designed to prepare individuals to render prehospital and interhospital BLS within an organized EMS system.]

Basic rescue practices technician -- An individual who [holds a valid certificate of successful completion of a rescue training program conducted in accordance with the training curriculum approved by the Department] is certified by the Department to possess the training and skills to perform a rescue operation as taught in a basic rescue practices technician program approved by the Department.

Basic vehicle rescue technician -- An individual who [holds a valid certificate of successful completion of a vehicle rescue training program conducted in accordance with the training curriculum approved by the Department] is certified by the Department to possess the training and skills to perform a rescue from a vehicle as taught in a basic vehicle rescue technician program approved by the Department.

Board certification -- Current certification in a medical specialty or subspecialty recognized by either the American Board of Medical Specialties or

the American Osteopathic Association.

CPR -- Cardiopulmonary resuscitation -- The combination of artificial respiration and circulation which is started immediately as an emergency procedure when cardiac arrest or respiratory arrest occurs[, by those properly trained and certified to do so].

CPR [Certification] course -- Cardiopulmonary resuscitation [certification] *course* -- A [certificate evidencing successful completion of a] course of instruction in CPR, meeting the [most current American Heart Association] Emergency Cardiac Care Committee National Conference on CPR and Emergency Cardiac Care standards. The [certification] course shall [have a current valid date and] encompass one and two-rescuer adult, infant and child CPR, and obstructed airway methods.

[*Closest available ambulance* -- An ambulance, which as a result of a combination of location and other factors, such as traffic conditions, weather, and the like, can reach a patient most promptly.]

Commonwealth Emergency Medical Director -- A medical command physician or a physician meeting the equivalent qualifications in §1003.1 (relating to Commonwealth Emergency Medical Director) and approved by the Department to advise, formulate and direct policy on matters pertaining to EMS.

Continuing education -- Learning activities intended to build upon the education and experiential basis of prehospital personnel for the enhancement of practice, education, administration, research or theory development, to strengthen the quality of care provided.

Continuing education sponsor -- An entity or institution that [applies to the Department and satisfies the Department's requirements to become an] is accredited by the Department as a sponsor of continuing education courses.

Council -- The [State Advisory Council, which shall be known as the] Board of Directors of the Pennsylvania Emergency Health Services Council.

Critical care specialty *receiving* facility -- A [F]facilit[ies]y identified by [their] its capability of providing specialized emergency and continuing care to patients

[within], including, but not limited to, one of the following medical areas: poisoning, neonatal, spinal cord injury, behavioral, burns, cardiac and trauma.

Department -- The Department of Health of the Commonwealth or a designee.

Department [*of Health certification*] *identification number* -- A number issued [through the Department's computer system] by the Department that identifies an individual who participates in the Statewide EMS system and, who has been certified [as an EMT, EMT-paramedic, EMT instructor, first responder, and the like. The certification includes the expiration date and status level.], recognized or otherwise assigned an identification number by the Department.

Direct support of EMS systems -- Activities, equipment and supplies that are involved in the planning, initiation, maintenance, expansion, or improvement of EMS systems.

EMS -- Emergency medical services -- The ALS and BLS services utilized in responding to the needs of an individual for immediate medical care to prevent loss of life or aggravation of physiological or psychological illness or injury.

[*EMS council* -- A nonprofit incorporated entity or appropriate equivalent whose function is to plan, develop, maintain, expand and improve EMS systems within a specific geographical area of this Commonwealth and which is deemed by the Department as being representative of health professions and major public and voluntary agencies, organizations and institutions concerned with providing EMS. See the definition of "regional EMS council."]

EMS system -- The arrangement of personnel, facilities and equipment for the effective and coordinated delivery of EMS required in the prevention and management of incidents which occur either as a result of a medical emergency or of an accident, natural disaster or similar situation.

EMSOF - Emergency Medical Services Operating Fund -- Monies appropriated to the Department pursuant to section 14(c) of the Act (35 P.S. §6934(c)) and which are not assigned to the Catastrophic Medical and Rehabilitation Fund.

EMS training institute -- Emergency medical services training institute -- An institute accredited by the Department to provide a course required for the certification or recognition of a prehospital practitioner.

EMS training manual -- Emergency medical services training manual -- A manual adopted by the Department and reviewed biennially by the Council to aid ALS service medical directors in determining whether EMT-paramedics and prehospital registered nurses have demonstrated competency in the knowledge and skills necessary to be granted or maintain medical command authorization.

EMT -- Emergency medical technician -- An individual trained to provide prehospital emergency medical treatment and certified as such by the Department in accordance with the current [NSC for basic EMTs] EMT-NSC, as set forth in this part.

EMT-NSC-- Emergency medical technician-National standard curriculum -- [The current National training program for emergency medical technicians] An outline of knowledge and skills recommended for the education and training of EMTs, as adopted by the United States Department of Transportation.

EMT-paramedic -- Emergency medical technician-paramedic -- An individual who is trained to provide prehospital emergency medical treatment at an advanced level and certified as such by the Department [under] in accordance with the current [NSC for EMT-paramedics] EMT-NSC, as set forth in this part.

EMT-paramedic NSC -- Emergency medical technician-paramedic National standard curriculum -- [The National training program for EMT-paramedics] An outline of knowledge and skills recommended for the education and training of EMT-paramedics, as adopted by the United States Department of Transportation.

Emergency -- A combination of circumstances resulting in a need for immediate medical intervention.

Emergency department -- An area of the hospital dedicated to offering emergency medical evaluation and initial treatment to individuals in need of emergency care. [An emergency department may be a section/division of the

medicine or surgery department, or may be organized as a separate department.]

FAA -- The Federal Aviation Administration.

FAA certification number -- An air taxi/commercial operator operating certificate number assigned by the FAA, authorizing the certificate holder to operate aircraft as required by 14 CFR Part 135 (relating to air taxi operators and commercial operators).

Facility -- A hospital.

Federal KKK standards -- The minimum standards and specifications for ambulance vehicles set up by the United States Department of Transportation [Federal KKK-A-1822-B 1985, and amendments or revisions thereto].

Federally declared emergency -- A state of emergency declared by the President of the United States, upon the request of a governor. Once the President declares the situation a "major disaster," the Federal government supplements State and local efforts to meet the crisis.

[*Field internship* -- A portion of a required EMT-paramedic training program during which the student obtains supervised experience on a licensed ALS unit.]

[*Field preceptor* -- A person who evaluates a student's performance in a prehospital setting and is approved by the ALS training institute medical director.]

First responder -- An individual who is certified by the Department as a first responder.

Health professional -- A [licensed] physician who has education and continuing education in ALS services and prehospital care or a prehospital registered nurse.

Hospital -- An institution having an organized medical staff which is primarily engaged in providing to inpatients by or under the supervision of physicians, diagnostic and therapeutic services or rehabilitation services for the care or rehabilitation of injured, disabled, pregnant, diseased, sick or mentally ill persons. The term includes a facility for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not a facility caring

exclusively for the mentally ill.

[*Incident location* -- The geographic site of an emergency usually indicated by a minor civil division code number.]

Invalid coach -- A vehicle primarily maintained, operated and intended to be used for routine transport of persons who are convalescent or otherwise nonambulatory and do not ordinarily require emergency medical treatment while in transit. The term does not include an ambulance or another EMS vehicle.

[Licensing agency -- The Department.]

Medical advisory committee -- An advisory body, composed of a majority of physicians, to advise [the] a regional[/State] EMS council or the Council on issues that have potential impact on the delivery of emergency medical care.

Medical audit -- A mechanism to evaluate patient care.

Medical command -- An order given [to a provider of EMS by an authorized medical command physician who meets qualifications prescribed by the Department] by a medical command physician to a prehospital practitioner in a prehospital, interfacility, or emergency care setting in a hospital, to provide immediate medical care to prevent loss of life or aggravation of physiological or psychological illness or injury.

Medical command authorization -- Permission given by the ALS service medical director, including an air ambulance medical director, to an EMT-paramedic or a prehospital registered nurse under §1003.28 (relating to medical command authorization) to perform, on behalf of an ALS ambulance service, ALS services pursuant to medical command or in accordance with Department approved regional EMS council transfer and medical treatment protocols when medical command cannot be secured, is disrupted or is not required pursuant to the approved regional EMS council transfer and medical treatment protocols.

Medical Command Base Station Course -- The course adopted by the Department for medical command physicians and ALS service medical directors which provides an overview of the medical command system and base station direction.

Medical command facility -- The distinct unit within a facility that contains the necessary equipment and personnel, as prescribed in §1009.1 (relating to operational criteria) for providing medical command to and control [to an ambulance service] over prehospital personnel when providing medical command.

Medical command facility medical director -- A medical command physician who meets the criteria established by the Department to assume responsibility [responsible] for the [medical] direction and control of the [medical command physicians at an accredited] equipment and personnel at a medical command facility.

Medical command physician -- A physician [licensed in this Commonwealth who meets the criteria set forth by the Department for a medical command physician and] who is approved by [the] a regional EMS council [medical director] to provide medical command [to prehospital and interhospital providers].

Medical [control] coordination-- A system which involves the medical community in all phases of the regional EMS system and consists of the following elements:

(i) Designation of a regional medical director.

(ii) Responsibility for [overall supervision] oversight to assure implementation of all medical requirements, with special emphasis on patient triage and medical treatment protocol.

(iii) Effective emergency medical planning and [designation] recommendation for Department recognition of on-line command facilities with medical command physicians who give orders to prehospital patient care providers.

(iv) Transfer and [M]medical treatment protocols.

(v) Technologic innovations which support the training and operations of the physicians giving orders to prehospital patient care providers.

(vi) Technologic innovations which support the training and operations of the EMS program and an effective process for accountability -- for example, records,

case review and audits.

[Medical protocols -- Written prescribed medical procedures, adopted by the regional EMS councils after consultation with the regional EMS medical advisory committee and approval by the Department. Review of medical protocols by the regional councils shall be made on an annual basis with notification to the Department of changes.]

Medical record -- Documentation of the course of a patient's condition and treatment, maintained to provide communication among health care providers for current and future patient care.

[*Medical service area* -- A specified geographic area within which responsibility for medical supervision and control is designated by a regional EMS council based upon factors such as patient flow patterns, area population and EMS call volumes.]

Medical treatment protocols -- Written prescribed medical procedures.

Mutual aid response -- Response by an ambulance unit to an emergency based on a written agreement between [EMS providers] ambulance services whereby the signing parties agree to lend aid to one another under conditions specified in the agreement.

NSC -- National Standard Curriculum.

[On-line communication -- Direct radio or telephonic communication.]

PALS course-- Pediatric advanced life support course -- A course in advanced pediatric life support sanctioned by the American Heart Association and the American Academy of Pediatrics.

PSAP -- Public safety answering point -- A communications center established to serve as the first point at which calls by or on behalf of patients are received requesting emergency medical assistance.

Patient -- An individual who is believed to be sick, injured, wounded or otherwise incapacitated and helpless and who needs immediate medical attention.

[Pennsylvania Field Protocols for BLS -- The most current BLS treatment

guidelines recommended by the Council's Medical Advisory Committee and approved by the Department as defined in the act.]

Pennsylvania Trauma Systems Foundation -- A nonprofit Pennsylvania corporation whose function is to accredit trauma centers in this Commonwealth.

Physician -- An individual who has a currently registered license to practice medicine or osteopathic medicine in the Commonwealth of Pennsylvania.

[*Prehospital ambulance trip report* -- A summary of each ambulance call to which an ambulance responds. The report shall contain information specified on forms provided by the Department.]

Prehospital personnel --[Personnel certified or recognized by the Department to render EMS to patients outside of the hospital setting.] Ambulance attendants, first responders, EMTs, EMT-paramedics, prehospital registered nurses and health professional physicians. Any one of these individuals is a "prehospital practitioner."

Prehospital Personnel [Training] Manual -- A manual developed by the Department and reviewed by the Council for the administration of ALS and BLS prehospital personnel training programs.

Prehospital registered nurse -- An individual who is recognized by the Department as such under §1003.25b (relating to prehospital registered nurse.)

[*Prescribing physician* -- A physician licensed in this Commonwealth who is either the medical command physician who has ordered the controlled substance or the receiving emergency department physician who has received the patient from the ALS unit and will be replacing the controlled substance. A prescribing physician shall possess a valid DEA number.]

[Primary response area -- The specified geographic area assigned to a licensed ambulance service that then has responsibility for the provision of prehospital emergency medical care and transportation in the area. Primary response areas are determined by regional EMS council plans, according to factors such as the location of ambulance resources, ambulance response times and area population. A primary response area designation is not intended to be

an exclusive designation.]

Providers of EMS -- A facility, BLS ambulance service or ALS ambulance service, or a QRS.

QRS -- Quick [R]response [S]service -- [A service which meets Department requirements and is strategically located to fill a response time gap if EMS cannot be provided within 10 minutes of the time a call for assistance is received.] An entity recognized by the Department to respond to an emergency and to provide EMS to patients pending the arrival of the prehospital personnel of an ambulance service.

[Quick responder -- A person responding as part of a designated quick response service which is strategically located within a specified EMS service area and is coordinated through the local and regional EMS response system. The personnel shall be trained and certified to the first responder level or higher.]

Receiving facility -- A fixed facility that provides an organized emergency department [of emergency medicine], with a [licensed and ACLS certified] physician who is trained to manage cardiac, trauma, and pediatric emergencies, and is present in the facility [who is] and available to the emergency department 24 hours-a-day, 7 days-a-week, and a registered nurse who is present in the emergency department 24 hours-a-day, 7 days-a-week. The facilit[ies]y shall also comply with Chapter 117 (relating to emergency services).

Regional EMS council -- A nonprofit incorporated entity or appropriate equivalent whose function is to plan, develop, maintain, expand and improve EMS systems within a specific geographical area of this Commonwealth and which is deemed by the Department as being representative of health professions and major public and voluntary agencies, organizations and institutions concerned with providing EMS in the region. [See the definition of EMS council.]

Registered nurse -- An individual who has a current original or renewed license to practice nursing in the Commonwealth of Pennsylvania as a registered nurse.

Rescue vehicle -- A vehicle which is designed or modified and equipped for rescue operations to release persons from entrapment and which is not routinely used for emergency medical care or transport of patients.

Rural area -- An area outside urbanized areas as defined by the United States Bureau of the Census.

Scope of practice -- Those emergency medical services that an individual who is certified or recognized by the Department is permitted to perform pursuant to the certification or recognition provided the individual has medical command authorization, if required.

Secretary -- The Secretary of the Department.

Service area -- The area in which an ambulance service routinely provides services.

Special care unit -- An appropriately equipped area of the hospital where provision has been made for a concentration of physicians, registered nurses and others who have special skills and experiences to provide medical care for critically ill patients.

Special event -- A planned and organized activity or contest, which will place [a group of 10,000 or more known or estimated] participants or attendees, or both, in a defined geographic area where access by emergency vehicles might be delayed due to crowd or traffic congestion at or near the event.

Special[ized] vehicle rescue [training] technician -- An individual who [holds a valid certificate of successful completion of a training program in specialized rescue training conducted in accordance with the curriculum approved by the Department] is certified by the Department to possess the training and skills to perform special rescue operations as taught in the special vehicle rescue training program approved by the Department.

State declared emergency -- An emergency declared by the Governor.

Statewide BLS medical treatment protocols -- Written medical treatment protocols adopted by the Department that have Statewide application to the delivery of BLS services by prehospital personnel.

[Transfer agreements -- A formal written agreement between facilities providing for transfer of patients to specialized facilities which offer follow-up care and rehabilitation as necessary to effect the maximum recovery of the patient.]

Trauma center -- A facility accredited as a trauma center by the Pennsylvania Trauma Systems Foundation.

[Vehicle licensure identification number -- A number issued by the Department to each ambulance of a ambulance service.]

§1001.3. Applicability.

[(a) This part implements the act.

(b)] This part affects regional EMS councils, the Council, other entities desiring to [contract with] receive funding from the Department or the regional EMS councils for the provision of EMS, ALS and BLS ambulance services, QRSs, instructors and institutes involved in the training of prehospital personnel including EMTs, EMT-paramedics, first responders, ambulance attendants and health professionals, and trauma centers and local governments involved in the administration and support of EMS.

§1001.4. Exceptions.

(a) The Department may, for justifiable reason, grant exceptions to, and departures from, this part when the policy objectives and intentions of this part are otherwise met or when compliance would create an unreasonable hardship, but would not impair the health, safety or welfare of the public. No exceptions or departures from this part will be granted if compliance with the [requirement is provided for] standard is required by statute.

(b) Requests for exceptions to this part shall be made in writing to the Department. The requests, whether approved or not approved, will be documented and retained on file by the Department. Approved requests shall be

retained on file by the applicant during the period the exception remains in effect.

(c) A granted request will specify the period during which the exception is operative. Exceptions may be reviewed or extended if the justifiable reasons for the original exception continue.

(d) An exception granted may be revoked by the Department for just cause. Just cause includes, but is not limited to, failure to meet the conditions for the exception. Notice of the revocation will be in writing and will include the reason for the action of the Department and a specific date upon which the exception will be terminated.

(e) In revoking an exception, the Department will provide for a reasonable time between the date of the written notice or revocation and the date of termination of an exception for the holder of the exception to come into compliance with this part. Failure to comply after the specified date may result in enforcement proceedings.

(f) The Department may, on its own initiative, grant an exception to this part if the substantive requirements of subsection (a) are satisfied.

§1001.5. Investigation.

[(a) The Department may investigate accidents involving an ambulance or other EMS vehicle.

(b) The Department may investigate complaints involving EMS providers or personnel.] The Department may investigate any person, entity or activity for compliance with the provisions of the act and this part.

§1001.6. Comprehensive EMS development plan.

(a) The Department, with the advice of the Council, will develop and annually update a Statewide EMS development plan for the coordinated delivery of EMS in this Commonwealth.

(b) The plan will contain, but not be limited to:

(1) An inventory of emergency services resources available in this Commonwealth.

(2) An assessment of the effectiveness of the existing services and a determination of the need for additional services.

(3) A statement of goals and specific measurable objectives for delivery of EMS to persons in need of the services in this Commonwealth.

(4) Methods to be used in achieving the stated objectives.

(5) A schedule for achievement of the stated objectives.

(6) A method for evaluating the stated objectives.

(7) Estimated costs for achieving the stated objectives.

(c) The Department will incorporate regional EMS development plans into the Statewide EMS development plan.

(d) The Department will adopt a Statewide EMS development plan, and updates to the plan, after public notice, an opportunity for comment, and its consideration of comments received, and shall make the plan available to the General Assembly and all concerned agencies, entities and individuals who request a copy.

§1001.7. Comprehensive regional EMS development plan.

(a) A regional EMS council shall develop and annually update a regional EMS development plan for coordinating and improving the delivery of EMS in the region for which it has been assigned responsibility.

(b) The plan shall contain:

(1) An inventory of emergency services resources available in the region.

(2) An assessment of the effectiveness of the existing services and a determination of the need for additional services.

(3) A statement of goals and specific measurable objectives for

delivery of EMS to persons in need of EMS in the region.

(4) Identification of interregional problems and recommended measures to resolve those problems.

(5) Methods to be used in achieving stated objectives.

(6) A schedule for achievement of the stated objectives.

(7) A method for evaluating whether the stated objectives have been achieved.

(8) Estimated costs for achieving the stated objectives.

(9) Other information as requested by the Department.

(c) A regional EMS council shall, in the course of preparing a regional EMS development plan, and updates to the plan, provide public notice and an opportunity for comment. It shall consider all comments before submitting a proposed plan to the Department.

(d) A regional EMS development plan shall become final after it is approved by the Department. The regional EMS council shall make the plan available to all concerned agencies, entities and individuals who request a copy.

Subchapter B. AWARD AND ADMINISTRATION OF [CONTRACTS] FUNDING

Sec.

1001.21. Purpose.

1001.22. Criteria for funding.

1001.23. Allocation of funds.

1001.24. Application for contract.

1001.25. Technical assistance.

1001.26. Restrictions on contracting.

1001.27. Subcontracting.

1001.28. Contracts with the Council.

§1001.21. Purpose.

This subchapter implements section 5(b)(2) of the act (35 P.S. §6925(b)(2)), which authorizes the Department to establish, by regulation, standards and criteria governing the award and administration of contracts under the act, and section 10 of the act (35 P.S. §6930), which authorizes the Secretary to enter into contracts with regional EMS councils and other appropriate entities for the initiation, expansion, maintenance and improvement of EMS systems which are in accordance with the Statewide EMS development plan, and which further authorizes the Secretary to enter into contracts with organizations other than regional EMS councils to assist the Department in complying with the provisions of the act.

§1001.22. Criteria for funding.

(a) A potential contractor or other recipient of funds from the Department, either directly or through the Department's agent, may receive funding for the following:

(1) Public education, information and prevention regarding EMS, including, but not limited to:

(i) Public education programs, including CPR, first aid, instruction regarding 911 systems and how to access EMS systems.

(ii) Public information programs, including passenger and driver safety specialty services and EMS system awareness programs.

(iii) Prevention programs, including passenger restraint systems, prudent heart living and general health awareness.

(2) Purchasing ambulances, medical equipment and rescue equipment which enables or enhances the delivery of EMS. Equipment will be funded only if approved by the Department.

(i) Ambulances will be considered for funding if the funds will be used for [expansion for the service] the addition or replacement of existing vehicles or parts, by a licensed ambulance service or an [ambulance service] entity submitting an application for licensure as an ambulance service. [Ambulances which are funded shall meet or exceed standards defined, published and distributed by the Department.]

(ii) Medical equipment will be considered for funding if the funds will be used to purchase medical equipment for ambulances, QRSs, [first responder agencies], rescue services and other emergency services approved by the Department, including police and fire departments and recognized medical command facilities.

(iii) Rescue equipment will be considered for funding if the funds will be used to purchase rescue equipment for ambulance services, rescue services, fire departments, QRSs, police agencies and other emergency services approved by the Department.

(3) Costs associated with training programs for prehospital personnel.

[(i) These funds will be provided only to EMS training facilities accredited by the Department for classes that include first responders, EMTs, EMT-paramedics, emergency services dispatchers, health professionals and rescue technicians.

(ii) Costs associated with the training programs in subparagraph (i) that will be eligible for funding include expenses associated with providing:

(A) Instructors.

(B) Course coordinators.

(C) Program medical directors.

(D) Clinical and field preceptors.

(E) Medical and nonmedical equipment and supplies.

(F) Field internships.

(G) Related travel expenses.

(H) Program directors.]

(i) Educational costs associated with the conduct of training programs for prehospital personnel, and for other personnel who are involved in managing interfacility patient transports.

[(iii)] (ii) Priority consideration will be given to training programs providing for certification, recertification, recognition and continuing education of individuals actively engaged in providing prehospital or interhospital EMS and rescue services.

(4) Costs associated with ambulance service inspections conducted to assist the Department with ambulance service licensure.

(5) Purchasing communications equipment, including medical command communications equipment, and alerting equipment for EMS purposes, if the purchases are in accordance with regional EMS council and Statewide telecommunications plans.

(6) Purchasing equipment for [hospital] emergency departments, if the equipment is used or intended to be used in equipment exchange programs with ambulance services. The equipment purchased shall be of a type used by prehospital and interhospital EMS personnel in the care, treatment, stabilization and transportation of patients in a prehospital or interhospital setting. It shall be the type of equipment that can be easily or safely removed from the patient upon arrival or during treatment at the receiving [medical] facility.

(7) Costs associated with the maintenance and operation of regional EMS councils. Items eligible for funding include:

(i) Salaries, wages and benefits of staff.

(ii) Travel.

(iii) Equipment and supplies.

(iv) Leasing of office space.

(v) Other costs incidental to the conduct of business which are found by the Department to be necessary and appropriate.

(8) Costs associated with the collection and analysis of data necessary to evaluate the effectiveness of EMS systems in providing EMS. These costs

may include the processing of both prehospital and hospital data and include the following:

(i) Data collection.

(ii) Data entry.

(iii) Data processing of information.

(iv) Analysis and evaluation of data.

(v) Dissemination and interpretation of data.

(9) Emergency allocations.

(i) Costs associated with a State or Federally declared emergency which the [Secretary] Department finds necessary to carry out the purpose of the act. Eligible applicants are those recognized by the regional EMS council as participants in the delivery of emergency medical or rescue services to or in the affected area.

(ii) Other emergency allocations found necessary by the [Secretary] Department to provide immediate resources or equipment to an area where the health and safety of the residents of this Commonwealth are in jeopardy.

(10) Costs associated with the implementation of voluntary certification or recognition programs, [including] such as a voluntary rescue service certification program.

(11) Other costs determined by the Department to be appropriate and necessary for the implementation of a comprehensive EMS system.

(b) [To be considered for funding, a potential contractor may not propose to provide] Funds shall not be made available for any of the following:

(1) Acquisition, construction or rehabilitation of facilities or buildings, except renovation as may be necessary for the implementation of 911 and EMS communication systems.

(2) The purchase of hospital equipment, unless the equipment is used or intended to be used in an equipment exchange program with ambulance services.

(3) Maintenance of ambulances, medical equipment or rescue equipment.

(4) Other costs found by the Department to be inappropriate.

(5) Costs which are normally borne by patients.

(c) The Department will set forth additional priorities for funding on a yearly basis in policies published by notice in the *Pennsylvania Bulletin.*

(d) The Department, by contract or notice published in the *Pennsylvania Bulletin*, may require a contractor or other applicant for funding to provide matching funds in specified percentages as a condition for receiving funds distributed by the Department or a regional EMS council.

§1001.23. Allocation of funds.

[(a)] The Department and regional EMS councils will consider the following factors in determining who shall receive funding and in what amount:

(1) The total amount of funds available.

(2) Conformity of the proposed application to the Statewide EMS development plan.

(3) Financial need of the applicant.

(4) [Source of other f]Funds available to the applicant for the purpose set forth in the application, including non-State contributions, Federal grants, or Federal contracts pertaining to EMS. Non-State contributions include cash and in-kind services provided to the contractor or toward the operation of an EMS system by private, public or government entities, including the Federal government.

(5) Economic base of the geographic area served by the applicant.

(6) Population of the geographic area served by the applicant.

(7) Special rural needs of the geographic area served by the applicant.

(8) Potential duplication of services.

(9) Priorities of the Department.

(10) Other factors set forth by the Department in published guidelines or policies.

[(b) The Department will set forth priorities for funding on a yearly basis in policies published by notice in the *Pennsylvania Bulletin*.]

§1001.24. Application for contract.

To be considered for funding by the Department to plan, initiate, maintain, expand or improve an EMS system, a regional EMS council or other appropriate entity shall submit an application on a form [presented] prepared by the Department[, including, but not limited to,] and shall provide the following information:

(1) The need for planning, initiation, maintenance, expansion or improvement of an EMS system.

(2) Data and information which demonstrate the qualifications of the applicant to plan, initiate, expand or improve an EMS system, and which include organizational structure and provision for representation of appropriate entities.

(3) The applicant's organizational structure.

§1001.25. Technical assistance.

(a) Regional EMS councils and other contracting entities may request technical assistance from the Department, if necessary, for the purpose of carrying out their contracts. Special consideration shall be given to contractors in rural areas.

(b) Technical assistance from the Department may also be available to subcontractors when technical assistance resources are not available from the regional EMS council designated for the applicable area.

(c) Examples of technical assistance resources include, but are not limited to:

(1) Telecommunications specialists.

(2) Public education resources.

(3) Management information sources.

§1001.26. Restrictions on contracting.

(a) The Department will not contract, during the same term of contract, [for the organization of] with more than one regional EMS council [which covers the same geographic area or a substantial] to exercise responsibility for all or a portion of the same geographic area.

(b) A regional EMS council or other contractor does not have the right to have a contract renewed.

§1001.27. Subcontracting.

(a) A regional EMS council, which has received a contract from the Department, may receive the Department's written approval to subcontract certain of its contractual duties to other [EMS] entities as deemed necessary and appropriate for the proper execution of the contract with the Department.

(b) A subcontract may not be executed until the Department determines in writing that the subcontract is necessary and appropriate.

(c) Subcontractors will be paid on a cost reimbursement basis. The costs will be determined by the Department based on documentation submitted to the Department.

§1001.28. Contracts with the Council

Sections 1001.22 through 1001.27 do not apply to contracts between the Department and the Council. The Department will contract with the Council to provide it funds to perform the services the Council is required to perform under

the act, and may contract with the Council for it to assist the Department in complying with other provisions of the act.

Subchapter C. COLLECTION OF DATA AND INFORMATION

Sec.
1001.41. Data and information requirements for ambulance services.
1001.42. Dissemination of information.

§1001.41. Data and information requirements for ambulance services.

(a) Ambulance services licensed to operate in this Commonwealth shall collect, maintain and report accurate and reliable patient data and information for calls for assistance [in the format prescribed and on forms provided by the Department within a specified time period]. The report shall be made by completing an ambulance call report.

[(b) The information collected shall include, but not be limited to:

(1) Ambulance service affiliate number and vehicle identification number.

(2) Ambulance trip report number.

(3) Patient sex and age.

(4) Patient vital signs.

(5) Incident location.

(6) Type of incident.

(7) Classification of the call at time of dispatch as either emergency or nonemergency.

(8) Date of call.

(9) Times as follows:

(i) Time call received for dispatch of ambulance service.

(ii) Time of dispatch of responding ambulance.

(iii) Time of ambulance responding to incident scene.

(iv) Time of ambulance arrival at the scene.

(v) Time extrication was completed.

(vi) Time of ambulance departure from the scene.

(vii) Time of ambulance arrival at facility.

(viii) Time ambulance available for further service.

(10) Patient condition at the time emergency personnel arrived at the scene and arrived at the receiving facility.

(11) History of present illness or injury.

(12) Type of injury or illness.

(13) Anatomic site of injury or illness.

(14) Seriousness of patient illness or injury.

(15) Highest level of care rendered to the patient.

(16) Treatments, aids and medications given.

(17) Indication of mutual aid response.

(18) If mutual aid response, time of initial dispatch for the incident.

(19) Times medications or treatment, or both were rendered.

(20) Medical command: time, type and quality of transmission.

(21) Type of telecommunication utilized to notify receiving facility.

(22) Department identification number of medical command physician, when medical command is obtained.

(23) Each ambulance crew member's name, level of EMS training, and Department ID number if assigned.

(24) Indication that CPR was in progress before arrival; for example, citizen, QRS, first responder, if applicable.

(25) Support services utilized; for example, rescue, fire, helicopter or coroner.

(26) Indication that QRS was utilized, if applicable.

(27) If utilized, the QRS's arrival time at the scene of the incident.

(28) Receiving facility and location.

(29) Documentation regarding refusal of care by patient.

(30) Documentation regarding a decision that emergency care and transportation were not needed.

(31) Information regarding patient seat belt usage, if pertinent and available.] The Department shall identify data items for the ambulance call report as either confidential or not confidential.

(c) [No person or ambulance service may disseminate the information collected under this section except as provided in §1001.42 (relating to dissemination of information). Licensed] An ambulance service[s] shall [provide to the Department evidence that] store the information designated as confidential in secured areas to assure that access to unauthorized persons is prevented, and shall take other necessary measures to ensure that such information is maintained in a confidential manner and is not available for public inspection or dissemination, except as authorized by §1001.42 (relating to dissemination of information). [Ambulance services that fail to maintain confidentiality of information are subject to suspension, revocation or denial for license as provided for in Chapter 1005 (relating to licensing of BLS and ALS ambulance services).]

(d) When an ambulance service transports a patient to a hospital, before its ambulance departs from the hospital, it shall provide to the individual at the hospital assuming responsibility for the patient, either verbally, or in writing or other means by which information is recorded, the patient information designated in the ambulance call report as essential for immediate transmission for patient care. Within 24 hours following the conclusion of its provision of services to the patient, the ambulance service shall complete the full ambulance call report and provide a copy or otherwise transmit the data to the receiving facility.

(e) The ambulance service shall have a policy for designating which member of the ambulance crew is responsible for completing the ambulance call report.

§1001.42 Dissemination of information.

(a) No person who collects, has access to, or knowledge of, confidential information collected under §1001.41 (relating to data and information requirements for ambulance services), by virtue of that person's participation in the statewide EMS system, may provide the ambulance call report, or disclose the [knowledge] confidential information contained in the report or a report or record thereof, except:

(1) To another person who by virtue of his office as an employee of the Department is entitled to obtain the information.

(2) To another person or agency under contract with or licensed by the Department and subject to strict supervision by the Department to insure that the use of the data is limited to specific research, planning [and], quality [assurance] improvement and complaint investigation purposes and that appropriate measures are taken to protect patient confidentiality.

(3) To the patient who is the subject of the information released or the patient's designee or assigned heirs.

(4) Under an order of a court of competent jurisdiction.

(5) For the purpose of quality [assurance] improvement activities, with strict attention to patient confidentiality.

(6) For the purpose of data entry/retrieval and billing, with strict attention to patient confidentiality.

(b) [A person or organization in the possession of patient identifying data or records, shall store the information in secured areas to assure that access to unauthorized persons is prohibited.] The Department shall regularly disseminate non-confidential, statistical data collected from ambulance call reports to providers of EMS for improvement of services.

Subchapter D. QUALITY [ASSURANCE] IMPROVEMENT PROGRAM

Sec.
1001.61. Components.
1001.62. Regional programs.
1001.63. [Medical command facilities.] **(Reserved).**
1001.64. [Ambulance services.] **(Reserved).**
1001.65 Cooperation

§1001.61. Components.

(a) The Department, in conjunction with the Council, will identify the necessary components for a Statewide EMS quality [assurance] improvement program for the Commonwealth's EMS system. The Statewide EMS quality improvement program shall be operated to monitor the delivery of EMS through the collection of data pertaining to emergency medical care provided by prehospital personnel and providers of EMS.

(b) The Department will develop, approve, and update a Statewide EMS Quality Improvement Plan in which it shall establish goals and reporting thresholds.

§1001.62. Regional programs.

A regional EMS council, after considering input from participants in and persons served by the regional EMS system, shall develop and implement a regional EMS quality [assurance] improvement program to monitor the delivery

of EMS, which addresses, at a minimum, the quality [assurance] improvement components identified by the Department. A regional EMS council quality improvement program shall:

(1) Conduct quality improvement audits on the regional EMS system including reviewing the quality improvement activities conducted by the ALS service medical directors and medical command facilities within the region.

(2) Have a regional quality improvement committee that shall recommend to the regional EMS council ways to improve the delivery of prehospital EMS care within the region based upon state and regional goals and reporting requirements.

(3) Develop and implement a regional EMS quality improvement plan to assess the EMS system in the region.

(4) Investigate complaints concerning the quality of care rendered and forward recommendations and findings to the Department.

(5) Submit to the Department reports as prescribed by the Department.

§1001.63. [Medical command facilities.] (Reserved).

[A medical command facility accredited by the Department shall actively participate in quality assurance programs approved by the Department.]

§1001.64. [Ambulance services.] (Reserved).

[An ambulance service licensed to operate in this Commonwealth shall actively participate in quality assurance programs approved by the Department. The quality assurance programs shall incorporate prehospital data summary information required by the Department.]

§1001.65. Cooperation.

Each individual and entity licensed, certified, recognized, accredited or otherwise authorized by the Department to participate in the Statewide EMS system shall cooperate in the Statewide and regional EMS quality improvement programs, by providing data, reports and access to records as requested by the Department and regional EMS councils to monitor the delivery of EMS.

Subchapter E. TRAUMA CENTERS

Sec.
1001.81. Purpose.
1001.82. Requirements.
1001.83. Complaints.
1001.84. Statistics.

§1001.81. Purpose.

The [Department has the duty] purpose of this subchapter is to integrate trauma centers into the Statewide EMS system, by providing access to trauma centers and by providing for the effective and appropriate utilization of resources.

§1001.82. Requirements.

(a) To ensure that trauma centers are integrated into the Statewide EMS system, [accredited] trauma centers in this Commonwealth shall:

(1) Maintain a dedicated telephone number to allow for access by referring community hospitals to make arrangements for the most appropriate and expeditious mode of transportation to the trauma center, as well as allow for direct consultation between the two facilities prior to transfer and during the course of treatment of the patient.

(2) Develop and implement outreach education programs to be offered to referring hospitals and emergency services dealing with management of major and multiple systems trauma patients and the capabilities of the trauma center.

(3) Develop and institute a system to insure the provision of patient outcome and treatment information to the referring facility on each patient referred by that facility to the trauma center.

(4) Maintain communications capabilities to allow for direct access by a transferring ground ambulance or [helicopter] air ambulance to insure that patient information and condition updates are available and medical consultation is available to the transferring service. The capabilities shall be in accordance with regional and Statewide EMS telecommunications plans.

§1001.83. Complaints.

The Department will investigate complaints related to the delivery of services by trauma centers and forward the results of the investigation to the accrediting entity with a recommendation for action.

§1001.84. Statistics.

The Department will compile and maintain statistics on mortality and morbidity on multi-system trauma victims. This data collection shall be coordinated and performed in conjunction with other collection activities.

Subchapter F. REQUIREMENTS FOR REGIONAL EMS COUNCILS AND THE COUNCIL

Sec.

1001.101. Governing body.

1001.102. [Council director.] **(Reserved).**

1001.103. [Personnel.] **(Reserved).**

§1001.101. Governing body.

A regional EMS council and the Council shall have a governing body[, whether a unit of local government or a public or private nonprofit entity. Responsibility for the contract will rest in the governing body].

(1) No more than one staff member of the regional EMS council or Council may sit on the governing body at the same time.

(2) If the governing body consists of a board, it shall adopt written policies which include, but are not limited to:

(i) A method of selection for membership.

(ii) Qualifications for membership.

(iii) Criteria for continued membership.

(iv) Frequency of meetings.

(3) The duties of the governing body shall include, but not be limited to:

(i) Selecting a director as the person officially responsible to the governing body.

(ii) Identifying the purpose and philosophy.

(iii) Describing the organizational structure.

(4) The governing body shall make available to the public an annual report which includes, but is not limited to:

(i) Activities and accomplishments of the preceding year.

(ii) A financial statement of income and expenses.

(iii) A statement disclosing the names of officers and directors.

§1001.102. [Council director.] (Reserved).

[The director shall:

(1) Prepare and annually update written policies and procedures.

(2) Assist the governing body in formulating policy and present the following to the governing body at least annually:

(i) Project goals and objectives which include time frames and available resources.

(ii) Written reports of project operations.

(iii) A performance report summarizing the progress towards meeting goals and objectives.]

§1001.103. [Personnel.] (Reserved).

[The governing body shall:

(1) Adopt and implement written project personnel policies and procedures which include, but are not limited to:

(i) Recruitment, selection, promotion and termination of staff.

(ii) Utilization of volunteers.

(iii) Wage and salary administration.

(iv) Employee benefits.

(v) Working hours.

(vi) Vacation and sick leave.

(vii) Rules of conduct.

(viii) Disciplinary actions.

(ix) Supervision of staff.

(x) Work performance evaluations.

(xi) Employee accidents and safety.

(xii) Employee grievances.

(2) Adopt a written policy to implement and coordinate personnel management, which includes, but is not limited to, confidential maintenance of personnel records.

(3) Develop written policies and procedures to provide for ongoing staff development. Documentation includes, but is not limited to, an assessment of staff training needs and plans for addressing these needs.

(4) Maintain records on an employee which include, but are not limited to:

(i) An application for employment.

(ii) The results of reference investigations.

(iii) Verification of training experience and professional licensure or registration, if applicable.

(iv) Salary information.

(v) A work performance evaluation.

(vi) Disciplinary actions.

(5) Develop written policies on employee rights, and document efforts by the project to inform staff of the following:

(i) The employee's right to inspect his own records.

(ii) The employee's right to request the correction or removal of inaccurate, irrelevant, outdated or incomplete information from the records.

(iii) The employee's right to submit rebuttal data or memoranda to his own records.

(6) Develop written job descriptions or project positions which include but are not limited to:

(i) A job title.

(ii) Tasks and responsibilities of the job.

(iii) Prerequisite skills, knowledge and experience.]

Subchapter G. ADDITIONAL REQUIREMENTS FOR REGIONAL EMS COUNCILS

Sec.
1001.121. Designation of regional EMS councils.
1001.122. Purpose of regional EMS councils.
1001.123. Responsibilities.
1001.124. Composition.
1001.125. Requirements.

§1001.121. Designation of regional EMS councils.

(a) The Department will designate a[n] regional EMS council that satisfies the representation requirements in §1001.125 (relating to requirements) for each geographic area of this Commonwealth.

(b) The designation of the geographical area will be based on:

(1) Existing usual patient care flow patterns.

(2) The capability to provide definitive care services to the majority of general, emergent and critical patients.

(3) Financial resources to sustain the EMS system operations.

(4) The capability to establish community-wide and regional care programs.

(c) The Department will evaluate the performance and effectiveness of each regional EMS council on a periodic basis to assure that each council is appropriately meeting the needs of its region in planning, developing, maintaining, expanding, improving and upgrading the [emergency medical services] EMS system in its region.

§1001.122. Purpose of regional EMS councils.

Regional EMS councils shall assist the Department in carrying out the act and this part and shall adhere to policy direction established by the Department.

§1001.123. Responsibilities.

In addition to other responsibilities imposed upon regional EMS councils by this part, [The] regional EMS councils have responsibility for the following:

(1) Organizing, maintaining, implementing, expanding and improving the EMS system within the [identified] geographic area [of] for which the regional EMS council has assigned responsibilities.

(2) Developing and implementing comprehensive EMS plans, as approved by the Department. [The plans are subject to approval by the Department and shall include the designation of primary response areas.]

(3) Advising PSAPs, and municipal and county governments, as to EMS resources available for dispatching and any recommended dispatching criteria that may be developed by the Department, or by the regional EMS council as approved by the Department.

[(3)] (4) Developing, maintaining, implementing, expanding and improving programs of medical [control and accountability] coordination. The programs are subject to approval by the Department.

[(4)] (5) Assisting hospitals in providing the Department with a comprehensive written plan for emergency care based on community need as provided in §117.11 (relating to emergency services plan) and in identifying the hospital's scope of services as provided in §117.13 (relating to scope of services).

[(5)] (6) Assisting the Department in achieving a unified Statewide EMS system as described in section 4 of the act (35 P.S. §6924).

[(6)] (7) Assisting the Department in collection and maintenance of

standardized patient data and information.

[(7)] (8) Providing [licensed] ambulance services with data summary reports.

[(8) Preparing plans for implementing, expanding, improving and maintaining EMS systems in the area. The plan shall contain information as prescribed by the Secretary.]

[(9) Carrying out, to the extent feasible, the EMS system plans.]

[(10)] (9) Assuring the reasonable availability of training programs, including continuing education programs, for EMS personnel. The programs shall include those that lead to certification or recognition by the Department. Regional EMS councils may also develop and implement additional educational programs.

[(11)] (10) Monitoring medical command facilities and [medical control and accountability of] prehospital [emergency] personnel [for] compliance with minimum standards established by the Department, and ambulance service medical director and medical command physician medical control of prehospital personnel.

[(12)] (11) [Developing processes and procedures for] Facilitating the integration of medical command facilities into the regional EMS system in accordance with policies and guidelines established by the Department.

[(13) Determining system needs and recommending the allocation of resources based upon this need assessment. Guidelines for needs assessment will be provided by the Department and shall be consistent with the State EMS plan.]

[(14) Establishing and implementing criteria for the evaluation or referral of acutely ill and injured persons for transport to the most appropriate facilities in accordance with policies, guidelines and criteria established by the Department. The criteria shall address the treatment and transfer of trauma, cardiac, spinal cord, poison, burns, neonatal and behavioral patients. Facilities in the region may participate on a voluntary basis in the categorization process established by the Department.]

[(15)] (12) Developing and implementing regional protocols for the triage, treatment, transport and transfer of patients to the most appropriate facility. Protocols shall be developed [by the] in consultation with the regional EMS council's medical advisory [and facilities] committee[s] and approved by the [Secretary or a designee] Department. Protocols shall, at a minimum:

(i) Include a method of identifying patients requiring specialized medical care, utilizing measurable criteria to identify patient referral[, including, but not limited to, the seven critical care groups identified in paragraph (14). The Department will provide guidelines for recommended protocols].

(ii) Be based upon the specialty care capabilities of the receiving facilities and available providers of [prehospital] EMS [providers,] prehospital personnel, local geodemographic considerations and transport time considerations.

(iii) Be distributed to the providers of EMS within the region.

(iv) Be reviewed annually, and revised as necessary in consultation with the regional EMS council's [regional] medical advisory committee.

(v) Be consistent with Chapter 1003 (relating to personnel) which governs the scope of practice of [emergency medical technicians, paramedics] EMTs, EMT-paramedics and other prehospital [EMS] personnel.

(vi) Be based upon accepted standards of emergency medical care.

(vii) [Prohibit patient transfer unless it is for medical necessity or upon request of the patient.] Address patient choice regarding receiving facility.

[(viii) Require written transfer agreements between appropriate facilities.]

[(ix)] (viii) Set forth a procedure for the efficient transfer of patients. When appropriate, these regional protocols shall be developed in consultation with specialty care facilities in the region. [The transfer protocols shall contain the following requirements:

(A) The process of transferring patients from one facility to another shall be carried out as expeditiously as possible.

(B) The receiving facility shall have at least one staff person available 24 hours-a-day, 7 days-a-week, who, without consultation from other personnel, has the authority to approve or disapprove transfers.

(C) If the facility is [designated as] a critical care specialty receiving hospital and that hospital disapproves a transfer from another facility, that hospital shall participate in a backup network which will identify another available receiving facility.

(D) Providers involved in a transfer shall insure that necessary patient information and records will accompany the patient. Prehospital and interhospital personnel shall be advised of patient care needs during the transfer. Hospital personnel accompanying the patient shall be familiar with the ambulance and hospital equipment accompanying the patient, and capable of operating the equipment for appropriate administration of care to the patient.]

[(16) Developing a program to assess the quality of EMS system in its region and investigating complaints concerning the quality of care rendered and forwarding recommendations and findings to the Department in regard to each complaint investigated. Complaint investigations shall be conducted in accordance with administrative rules and procedures and written documentation of facts and findings shall be provided the Department. Quality assurance programs implemented by regional EMS councils shall be consistent with guidelines prescribed by the Department.]

[(17) Developing a review process for investigating complaints received by either the council or the Department concerning care rendered by prehospital personnel or providers.]

[(18)] (13) Assisting Federal, State or local agencies, upon request, in the provision of onsite mitigation, technical assistance, situation assessment, coordination of functions or postincident evaluations, in the event of a potential

or actual disaster, mass casualty situation or other substantial threat to public health.

[(19)] (14) Maintaining an [EMS resource] inventory of EMS resources and personnel available on a volunteer basis as conditions and circumstances require. Recruitment of volunteer expertise available shall be requested when needed.

[(20)] (15) Designating a regional medical director [subject to approval by the Department].

[(21)] (16) Supervising the regional EMS medical director to assure that the roles and responsibilities in §1003.2 (relating to regional EMS medical director) are carried out.

(17) Assisting prehospital personnel and ambulance services operating in the regional EMS system to meet the licensure, certification, recertification, recognition, biennial registration and continuing education requirements established under the act and this part, and assisting the Department in ensuring that those requirements are met.

(18) Apprising medical command facilities and ALS ambulance services in the region when an EMT-paramedic or prehospital registered nurse has had medical command authorization removed by an ALS ambulance service in the region.

(19) Developing a conflict of interest policy and require all employees and officials to agree to the policy in writing.

[(22)] (20) Performing other duties deemed appropriate by the Department.

§1001.124. Composition.

Regional EMS councils shall be organized by one of the following:

(1) A unit of general local government with an advisory council.

(2) A representative public entity administering a compact or other areawide arrangement or consortium.

(3) A public or private nonprofit entity.

§1001.125. Requirements.

(a) If the regional EMS council is a unit of local government, it shall have an advisory council which is [broadly representative of EMS providers, public safety agencies, health care facilities, consumers and elected public officials] deemed by the Department to be representative of health care consumers, the health professions, and major private and public and voluntary agencies, organizations and institutions concerned with providing EMS.

(b) If the regional EMS council is a public or private nonprofit organization, its governing body shall [be representative of the following:

(1) EMS providers.

(2) Public safety agencies.

(3) Health care facilities.

(4) Consumers.

(5) Elected public officials] satisfy the representation requirements set forth in subsection (a).

(c) A regional EMS council shall establish and maintain a medical advisory committee and other committees which are necessary to carry out the responsibilities of the regional EMS council.

(d) The regional[/State] medical advisory committee shall assist the regional EMS council's medical director in matters of medical [control] coordination [, and a majority of its members shall be physicians].

(e) Meetings of the regional EMS council shall be held under the Sunshine Act (65 P.S. §§271-286).

Subchapter H. ADDITIONAL REQUIREMENTS FOR THE COUNCIL

Sec.
1001.141. Duties and purpose.
1001.142. Meetings and members.
1001.143. Disasters.

§1001.141. Duties and purpose.

The Council shall advise the Department on emergency health services issues that relate to manpower and training, communications, ambulance services, special care units, the content of ambulance call reports, the content of rules and regulations, standards and policies promulgated by the Department and other subjects as required by the act or deemed appropriate by the Department or the Council. The Council shall also advise the Department on the content of the Statewide EMS development plan, and proposed revisions to it.

§1001.142. Meetings and members.

(a) Meetings of the Council shall be held under the Sunshine Act (65 P.S. §§271-286).

(b) A voting member of the Council shall serve a 3-year term. A voting member may not serve more than two consecutive terms.

(c) A simple majority of the voting members of the Council constitutes a quorum for the transaction of business.

(d) A member of the Council shall serve without compensation, except for reimbursement of reasonable expenses incurred by members while performing

official duties.

§1001.143. Disasters.

In the event of a potential or actual disaster, mass casualty situation or other substantial threat to public health, the Council shall, upon request, assist Federal, State and local agencies in the provision of onsite mitigation, technical assistance, situation assessment, coordination of functions or postincident evaluations. Recruitment of volunteer expertise available to the Council will be requested and utilized as conditions and circumstances necessitate.

Subchapter I. RESEARCH IN PREHOSPITAL CARE

Sec.
1001.161. Research.

§1001.161. Research.

(a) [Proposals for c] Clinical investigations or studies that relate to direct patient care shall not be conducted by providers of EMS [shall be] unless the investigation or study is proposed to and approved by the Department. [An investigation or study may not be undertaken unless approved.]

(b) A proposal for clinical investigation or study shall be presented to the [regional medical director, the medical advisory committee of the regional EMS council, the medical advisory committee of the Council and the Commonwealth Emergency Medical Director for review and comment. Recommendations shall be forwarded to the Department within 60 days from the date the proposal is submitted] Department. If the Department concludes that the proposal may have merit, it shall refer the proposal to the Council, and to the regional EMS council having responsibilities in the region where the investigation or study would be undertaken. The Council and the regional EMS council shall have the proposal reviewed by their medical advisory committees and consider the comments of those committees, and shall forward their recommendations to the Department within 60 days after receiving the proposal from the Department.

(c) The Department will approve or disapprove the proposal within 30 days after receiving the recommendations of the Council and the regional EMS council. If the proposal is approved, the [EMS] prehospital personnel identified in the proposal may function in accordance with the proposal and under conditions specified by the Department during the term of the clinical

investigation or study.

(d) A proposal shall include and address the following considerations and items in a format specified by the Department:

(1) A specific statement of the hypothesis to be investigated and the clinical significance of the hypothesis.

(2) A specific description of the methodology to be used in the investigations.

(3) An estimated duration of the investigation.

(4) Consideration of complications or side effects that may be encountered and how they shall be treated.

(5) Consideration of how to assure patient confidentiality.

(6) Consideration of obtaining informed consent of the patient.

(7) [A letter approving the investigation from the appropriate regional EMS council.] Institutional review board approval when required by law.

(8) A letter from the researcher who identifies himself as the lead investigator and assumes clinical responsibility for the investigation.

(9) A letter from the physician who assumes clinical responsibility for the investigation.

(10) A plan for providing the Department with progress reports and a final report on the investigation or study.

(e) The Department may direct that the investigation or study be terminated prematurely for its failure to satisfy conditions of approval.

CHAPTER 1003. PERSONNEL

Subch.		Sec.
A.	ADMINISTRATIVE AND SUPERVISORY EMS PERSONNEL	1003.1
B.	PREHOSPITAL [EMS] AND OTHER PERSONNEL	1003.21
C.	[AIR AMBULANCE PERSONNEL	1003.41]
	(Reserved).	

Subchapter A. ADMINISTRATIVE AND SUPERVISORY EMS PERSONNEL

Sec.

1003.1. Commonwealth Emergency Medical Director.

1003.2. Regional EMS medical director.

1003.3. Medical command facility medical director.

1003.4. Medical command physician.

1003.5. ALS service medical director.

§1003.1. Commonwealth Emergency Medical Director.

(a) *Roles and responsibilities.* The Commonwealth Emergency Medical Director is responsible for the following:

(1) Providing medical advice and recommendations to the Department regarding the EMS system.

(2) Assisting in the development and implementation of a Statewide EMS quality [assurance] improvement program.

(3) Assisting the Department in revising or modifying the scope of practice of ALS and BLS prehospital personnel.

(4) Providing advice and guidance to the Department on investigations and the pursuit of disciplinary actions against prehospital personnel and providers of EMS.

(5) Reviewing and evaluating regional transfer and medical treatment protocols and making recommendations for the Statewide BLS medical treatment protocols and Statewide [medical protocols] criteria for the evaluation, triage, treatment, transport, transfer and referral, including bypass protocols of acutely ill and injured persons to the most appropriate facility.

(6) Evaluating regional EMS quality [assurance] improvement programs.

(7) Providing direction and guidance to the regional EMS medical directors for training and quality [assurance activities] improvement monitoring and assistance.

(8) Meeting with [directors] representatives and committees of regional EMS councils and the Council as necessary and as directed by the Department to provide guidance and direction.

(9) Providing other services relating to the Department's administration of the act as assigned by the Department.

(b) *Equivalent qualifications.* If the Commonwealth Emergency Medical Director is not a medical command physician, the Commonwealth Emergency

Medical Director shall possess the following qualifications:

(1) The minimum qualifications for a medical command physician in §1003.4(b)(1)-(3) and (5) (relating to medical command physician),

(2) Experience in the prehospital and emergency department care of the acutely ill and injured patient.

(3) Knowledge regarding the base station [radio] direction of prehospital personnel and the operation of emergency dispatch.

(4) Knowledge of the capabilities and limitations of ambulances, including air ambulances and prehospital personnel.

(5) Knowledge of potential medical complications which may arise during transport of a patient by an ambulance service.

(c) *Disclosure.* The Commonwealth Emergency Medical Director shall disclose to the Department all financial or other interest in providers of EMS and in other matters which present a potential conflict of interest.

§1003.2. Regional EMS medical director.

(a) *Roles and responsibilities.* Each regional EMS council shall have a regional EMS medical director who shall carry out the following duties:

(1) Assist the regional EMS council to [A]approve or reject applications for medical command physicians received from medical command facility medical directors.

(2) Maintain liaison with the Commonwealth Emergency Medical Director.

(3) [Establish and review system-wide medical protocols in] Assist the regional EMS council, after consultation with the regional medical advisory committee [and regional EMS council], to establish and revise transfer and medical treatment protocols for the regional EMS system.

[(4) Assist the Department in ensuring that personnel in the EMS system meet the certification, recertification, recognition, biennial registration and

continuing education requirements established under the act.]

[(5) Establish standards for EMS dispatch to assure that the an appropriate response unit is dispatched to the medical emergency scene and that proper patient evaluation is conducted.]

[(6)] (4) Assist the regional EMS council [E]establish field treatment protocols for determining when a patient will not be transported to a treatment facility and establish procedures for documenting the reasons for a nontransport decision.

[(7)] (5) Assist the regional EMS council [E]establish field protocols to govern situations in which a patient may be transported without consent, in accordance with Pennsylvania law. The protocols shall cover appropriate documentation and review procedures.

[(8)] (6) Assist the regional EMS council [E]establish criteria for level of care and type of transportation to be provided in various medical emergencies, such as ALS versus BLS, and ground versus air [specialty unit transportation] ambulance, and distribute approved criteria to PSAPs.

[(9) Establish operation standards for medical command facilities.]

[(10)] (7) Conduct quality [assurance] improvement audits of the regional EMS system including reviewing the quality [assurance] improvement activities conducted by the ALS service medical directors within the region.

[(11)] (8) Serve on the State EMS Quality [Assurance] Improvement Committee.

[(12)] (9) Serve as chairperson of the regional EMS council medical advisory committee.

[(13)] (10) Facilitate [and assure] continuity of patient care during inter-regional transport.

[(14) (11) Recommend to the Department suspension, [or] revocation or restriction of prehospital personnel certifications and recognitions.

[(15)] (12) Conduct hearings in accordance with §1003.28 (relating to medical command authorization) upon appeal of an individual whose medical command

authorization is denied or restricted by the ALS service medical director and issue written decisions.

[(16)] (13) Review regional plans, procedures and processes for compliance with State standards of emergency medical care.

[(17) Delegate portions of his authority to other qualified physicians.]

[(18) Meet with the ALS service medical directors within the region as necessary to disseminate information regarding State statutes, regulations, policies and direction.]

(b) *Minimum qualifications.*

(1) A regional EMS council medical director shall have the following qualifications:

(i) [A valid license to practice medicine in this Commonwealth as a doctor of medicine or doctor of osteopathy.] Licensure as a physician.

(ii) Experience in prehospital and emergency department care of the acutely ill or injured patient.

(iii) Experience in base station [radio] direction of prehospital emergency units.

(iv) Experience in emergency department management of the acutely ill or injured patient.

(v) Board certification in emergency medicine.

(vi) Experience in the training of basic and advanced prehospital personnel.

(vii) Experience in the medical audit, review and critique of BLS and ALS prehospital personnel.

(2) The [Secretary] Department may waive the board certification requirement upon written request by the regional EMS council.

(c) [*Medical Advisory Committee.* Each regional EMS council shall have a medical advisory committee to provide the council medical director with advice on issues relevant to the areawide EMS system.] *Disclosure.* A regional EMS medical director shall disclose to a regional EMS council all financial or other

interest in providers of EMS and in other matters which present a potential conflict of interest.

§1003.3. Medical command facility medical director.

(a) *Roles and responsibilities.* A medical command facility shall have a medical command facility medical director. A medical command facility medical director is responsible for the following:

(1) Medical command.

(2) Quality [assurance] improvement.

(3) Liaison with regional EMS council medical director.

(4) Participation in prehospital training activities.

(5) Clinical and continuing education training of prehospital [emergency care] personnel.

(6) Recommendations to the regional EMS medical director regarding medical command physician applications from [his institution] the medical command facility.

(b) *Minimum qualifications.*

(1) A medical command facility medical director shall have the following qualifications:

(i) Be a medical command physician.

(ii) Board certification in emergency medicine or, [in lieu of this, current ACLS and ATLS certification] have successfully completed the ACLS course within the preceding two years and the ATLS course, and either an APLS or PALS course, or other programs determined by the Department to meet or exceed the standards of those programs, along with board certification in surgery, internal medicine, family medicine, pediatrics or anesthesiology.

(iii) Experience in prehospital and emergency department care of the acutely ill or injured patient.

(iv) Experience in base station [radio] direction of prehospital

emergency units.

(v) Experience in the training of [basic] BLS and [advanced prehospital] ALS [emergency health] prehospital personnel.

(vi) Experience in the medical audit, review and critique of BLS and ALS prehospital personnel.

(2) The [Secretary] Department may waive the board certification requirements upon written request by the regional EMS council.

§1003.4. Medical command physician.

(a) *Roles and responsibilities.* A medical command physician shall [carry out the following duties]:

[(1) P]provide medical command to prehospital [emergency health] personnel. This shall include providing online medical command to prehospital personnel whenever they seek direction.

[(2) Assist with the duties of medical control.]

(b) *Minimum qualifications.* A medical command physician shall:

(1) [Hold a valid license to practice in this Commonwealth as a Doctor of Medicine or Doctor of Osteopathy.] Be a physician.

(2) Be board certified in emergency medicine or[, in lieu of this, be certified in] have successfully completed the [ATLS and] ACLS course within the preceding two years and the ATLS course, and either an APLS or PALS course, or other programs determined by the Department to meet or exceed the standards of those programs.

(3) Have [C]completed the [American Medical Association's (AMA's)] [C]continuing [M]medical [E]education [C]credits required for membership in the American Medical Association, or its equivalent, or be serving a [post]graduate year III in an approved residency program in emergency medicine or a [post]graduate year II in an approved residency program in emergency medicine with concurrent on-line supervision by an approved medical command physician.

(4) Be a full-time emergency physician or practice emergency medicine for at least half-time of a full-time medical practice.

(5) Possess a valid Drug Enforcement Agency (DEA) number.

(6) Have [C]completed the [base station m]Medical [c]Command Base Station [c]Course [within 2 years of the adoption of a course by the Department].

[(7) Be approved by the regional EMS medical director.]

(c) *Approval of medical command physician.*

(1) A physician may function as a medical command physician if approved to do so by a regional EMS council.

(2) A regional EMS council shall approve a physician as a medical command physician if the physician demonstrates that the physician will function under the auspices of a medical command facility and establishes either of the following:

(i) That the physician satisfies the qualifications for a medical command physician in subsection (b).

(ii) That the physician has received certification as a medical command physician from the Department upon successfully completing the voluntary medical command physician certification program administered by the Department.

(3) A regional EMS council shall conclude that the physician will be operating under the auspices of a medical command facility if the physician establishes either of the following:

(i) That the facility meets the requirements for a medical command facility prescribed in §1009.1 (relating to operational criteria).

(ii) That the facility has received recognition as a medical command facility from the Department pursuant to §1009.2 (relating to recognition process).

(d) *Notice requirements.*

(1) A medical command facility shall give notice to each regional EMS council having responsibility for an EMS region in which the medical command

facility anticipates medical command physicians functioning under its auspices will be providing medical command, and shall explain the circumstances under which medical command will be given in that region.

(2) A regional EMS council that has approved a physician as a medical command physician shall give notice of such approval to the Department.

(e) *Transfer and medical treatment protocols.* A medical command physician shall provide medical command to prehospital personnel in ground ambulances and QRSs consistent with the transfer and medical treatment protocols which are in effect in either the region in which treatment originates or the region in which the prehospital personnel begin receiving on-line medical command from the medical command physician.

§1003.5. ALS service medical director.

(a) *Roles and responsibilities.* An ALS service medical director is responsible for the following:

(1) Providing medical guidance and advice to the ALS ambulance service[.], including:

(i) Reviewing the Statewide BLS medical treatment protocols and the regional transfer and medical treatment protocols, and ensuring that the ALS ambulance service's prehospital personnel are familiar with them, and amendments and revisions thereto.

(ii) Providing guidance to the ALS ambulance with respect to the ordering, stocking and replacement of drugs, and compliance with laws and regulations impacting upon the ALS ambulance service's acquisition, storage and use of those drugs.

(iii) Participating in the regional and Statewide quality improvement plans, including continuous quality improvement reviews of patient care and its interaction with the regional EMS system.

(iv) Recommending to the relevant regional EMS council, when

appropriate, specific transfer and medical treatment protocols for inclusion in the regional transfer and medical treatment protocols.

(2) Granting [or], denying, or restricting medical command authorization to members of the ALS ambulance service's prehospital personnel who require this authorization, and participating in appeals from decisions to deny or restrict medical command authorization in accordance with [§1003.29] §1003.28 (relating to medical command authorization).

(3) Performing medical audits of patient care provided by the ALS ambulance service's prehospital personnel.

(b) *Equivalent qualifications.* If the ALS service medical director is not a medical command physician, the ALS service medical director shall:

(1) Possess the minimum qualifications for a medical command physician in §1003.4(b)(1)-(5) (relating to medical command physician).

(2) Have experience in the base station [radio] direction of prehospital personnel [and the operation of emergency dispatch].

(3) Have knowledge of the capabilities and limitations of ambulances, including air ambulances, and prehospital personnel.

(4) Have knowledge of potential medical complications which may arise during transport of the patient by an ambulance service.

(5) Successfully complete [Parts A and B of] the Medical Command Base Station Course [adopted by the Department].

Subchapter B. PREHOSPITAL [EMS] AND OTHER PERSONNEL

Sec.

1003.21. Ambulance attendant.
1003.22. First responder.
1003.23. EMT.
1003.23a. EMS instructor certification.
1003.24. EMT-paramedic.
1003.25. (Reserved).
1003.25a. Health professional physician.
1003.25b. Prehospital registered nurse.
1003.26. Rescue personnel.
1003.27. Disciplinary and corrective action.
1003.28. Medical command authorization.
1003.29. Continuing education requirements.
1003.30. Accreditation of sponsors of continuing education.
1003.31. Credit for continuing education.
1003.32. Responsibilities of continuing education sponsors.
1003.33. Advertising.
1003.34. Withdrawal of accreditation or course approval.

§1003.21. Ambulance attendant.

(a) *Roles and responsibilities.* [Attendants provide first aid in accordance with the American Red Cross First Aid standards and provide CPR in accordance with American Heart Association standards.] An ambulance attendant, as part of the crew of an ambulance or a QRS, may perform BLS activities within the ambulance attendant's scope of practice, as set forth in subsection (c), at the scene of an emergency or enroute to a facility. This section does not prohibit an ambulance attendant from providing BLS services

as a good Samaritan.

(b) [*Minimum q] Qualifications.* To qualify as an [A]ambulance attendant[s] an individual shall satisfy one of the following:

(1) Possess a [valid] current certificate evidencing successful completion of an advanced first aid course sponsored by the American Red Cross [or another advanced first aid course approved by the Department] and a certificate issued within the last two years evidencing successful completion of a CPR course.

(2) Possess a [valid CPR certification] current certificate evidencing successful completion of a course or courses which are determined by the Department to be equivalent to the requirements in paragraph (1).

[(3) Be at least 16 years of age.]

(c) *Scope of practice.* An ambulance attendant shall have the authority to provide the following BLS services if trained to do so:

(1) Patient assessment (including vital signs) and ongoing evaluation.

(2) Pulmonary or cardiopulmonary resuscitation and foreign body airway obstruction management.

(3) Administration of oxygen via a resuscitation mask, nasal cannula, non-rebreather mask, and bag valve mask.

(4) Insertion of oropharyngeal or nasopharyngeal airways.

(5) Oropharyngeal suctioning

(6) Assessment and management of cardiac, respiratory, diabetic shock, behavioral and heat/cold emergencies, as prescribed within an advanced first aid course meeting the requirements in subsection (b)(1) or (2).

(7) Emergency treatment for bleeding, burns, poisoning, seizures, soft tissue injuries, chest-abdominal-pelvic injuries, muscle and bone injuries, eye injuries, and childbirth (including care of the newborn), as prescribed within an advanced first aid course meeting the requirements in subsection (b)(1) or (2).

(8) Application of spinal immobilization devices and splinting materials, including traction splints.

(9) Basic triage and basic maneuvers to gain access to the patient.

(10) Patient lifting and moving techniques.

(11) Use of an automated external defibrillator when approved by the medical director of the ambulance service.

(12) Assist a prehospital practitioner who is above the level of first responder in the use of Department-approved automatic ventilators and pulse oximetry when approved by the medical director of the ambulance service.

(13) Other BLS services taught in a course in advanced first aid sponsored by the American Red Cross, provided the ambulance attendant has received training to perform those services in such a course or in an equivalent training program approved by the Department, and is able to document having received such training. The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the skills and services taught in the most recent course in advanced first aid sponsored by the American Red Cross. If the course sponsored by the American Red Cross teaches services in addition to advanced first aid, the Department will exclude those services from the published list.

§1003.22. First responder.

(a) *Roles and responsibilities.* A first responder may perform, at the scene of an emergency, enroute to a facility [or trauma center], or in an emergency setting in a facility, the BLS services set forth in subsection (e) to stabilize and improve a patient's condition until more highly trained [prehospital] personnel arrive [at the scene]. Following the arrival of more highly trained [prehospital] personnel, a first responder may continue to perform the BLS services within a first responder's scope of practice as set forth in subsection (e) under the direction of more highly trained [prehospital] personnel. This section does not prohibit a first responder from providing BLS services as a good Samaritan.

(b) *Certification.*

(1) The Department will certify as a first responder an individual who

meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Is 16 years of age or older.

(iii) Has successfully completed a first responder training course approved by the Department. The Department will publish annually in the *Pennsylvania Bulletin* a list of courses leading to first responder certification.

(iv) Has passed a written examination for first responder certification prescribed by the Department, or has passed an examination which the Department has determined to be equivalent in both content and manner of administration.

(v) Has passed a practical test of first responder skills prescribed by the Department, or has passed an examination which the Department has determined to be equivalent in both content and manner of administration.

(2) A first responder's certification is valid for 3 years, subject to disciplinary action under section 11(j.1) of the act (35 P.S. §6931(j.1)) and §1003.27 (relating to disciplinary and corrective action). [An individual who received certification as a first responder under the voluntary first responder certification program in existence prior to September 2, 1995, will be deemed certified. The certification is valid for 3 years from the date the certification was issued. Following expiration of the deemed certification, the recertification requirements set forth in subsection (c) apply.]

(c) *Recertification.* A first responder shall apply for recertification between 1 year and 60 days prior to expiration of the first responder's certification from the Department. Failure to apply for recertification in a timely manner may result in the individual not being recertified before the prior certification expires. The Department will recertify as a first responder an individual who meets the following qualifications:

(1) Completes an application on a form prescribed by the Department.

(2) Is or was previously certified as a first responder.

(3) Has [S]successfully complete[s]d one of the following:

(i) The first responder practical skills and written knowledge examination prescribed by the Department.

(ii) The continuing education requirements applicable to first responders set forth in §1003.29(a) (relating to continuing education requirements).

(d) [*Reciprocal certification*] *Certification by endorsement*.

(1) [The Department will grant first responder certification to an individual who is currently certified as a first responder in another state who meets the following qualifications:] For an individual who is 16 years of age or older and who is currently certified in another state as a first responder or as a person with similar responsibilities, the Department will endorse the following qualifications as equivalent to those in subsection (b):

(i) [Completes an application on a form prescribed by the Department] Successful completion of training curriculum which meets or exceeds the standards for the training course prescribed by the Department in subsection (b) (1) (iii).

(ii) [Is 16 years of age or older.] Successful completion of a written examination for first responder certification, or an equivalent certification, which is determined by the Department to meet or exceed the standards of the written examination prescribed by the Department pursuant to subsection (b)(1)(iv).

(iii) [Can demonstrate successful completion of a first responder training curriculum which is recognized by the Department as meeting or exceeding standards for the curriculum in the first responder training course approved by the Department, within the 2 years preceding submission of the application, or, in the alternative, successfully completes the Pennsylvania first responder training course approved by the Department.] Successful completion of a practical skills examination for first responder certification, or an equivalent certification, which is determined by the Department to meet or exceed the

standards of the practical skills examination prescribed by the Department pursuant to subsection (b)(1)(v).

[(iv) Has successfully completed written and practical certification examinations recognized by the Department as meeting or exceeding the standards of the examinations prescribed by the Department.]

(2) An individual whose first responder certification or equivalent certification in another state is expired at the time of application may seek to have the satisfaction of paragraph (1)(i) endorsed as equivalent to the satisfaction of subsection (b)(1)(iii), but shall [meet the requirements in paragraphs (1)(i)-(iii)] not be considered by the Department for endorsement of qualifications under paragraph (1)(ii) or (iii), and shall successfully complete the first responder practical skills and written knowledge examinations prescribed by the Department after making application for certification through examination.

(3) [Reciprocal c]Certification under this subsection is valid for 3 years. Upon expiration of [reciprocal] that certification[,] the individual [to whom the Department granted reciprocal certification] shall meet the requirements for recertification in subsection (c).

(e) *Scope of practice.* A first responder's [shall have authority to provide the following BLS services] scope of practice includes the BLS services which may be performed by an ambulance attendant as set forth in §1003.21(c) (relating to ambulance attendant), if the first responder has been trained to perform those services. [:

(1) Patient assessment and evaluation.

(2) Pulmonary or cardiopulmonary resuscitation.

(3) Administration of oxygen via an oxygen mask, nasal cannula, a bag valve mask or a manually operated positive valve unit.

(4) Application of oropharyngeal or nasopharyngeal airways and pocket masks.

(5) Oropharyngeal or nasopharyngeal suctioning.

(6) Emergency medical treatment prescribed within the first responder

training program for bleeding, shock, burns, heat and cold emergencies, poisoning, fractures and childbirth.

(7) Use of an automatic external defibrillator, when the use is approved by the regional EMS council in accordance with criteria established by the Department.

(8) Use of spinal immobilization devices.

(9) Use of Department approved automatic ventilators and pulse oximetry when approved by the medical director for the ambulance service after appropriate training.

(10) Other BLS services authorized by Department-approved regional EMS council transfer and medical treatment protocols or under medical command.]

A first responder's scope of practice also includes other BLS services taught in a first responder training course approved by the Department, provided the first responder has received training to perform those services in such a course, in a course which is determined by the Department to meet or exceed the standards of a first responder training course preapproved by the Department, or in a course for which a first responder may receive continuing education credit towards recertification, and is able to document having received such training. The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the services taught in first responder training courses most recently approved by the Department. If the approved course is not offered by the Department, the Department may exclude from the published list, services taught which the Department determines are not appropriate services to be performed by a first responder.

§1003.23. EMT.

(a) Roles and responsibilities.

[(1) The scope of practice of an EMT includes the BLS services which

may be performed by a first responder under §1003.22(e) (relating to first responder) and other BLS services involved in the rescue, triage and transfer and transport of emergency and nonemergency patients, under section 11(e) of the act (35 P.S. §6931(e)) and in accordance with the Department of Transportation EMT National Standard Curriculum, and amendments and revisions thereto.

(2) An EMT's scope of practice shall be limited to the activities listed in paragraph (1), except if the Secretary authorizes an EMT to perform additional activities.]

An EMT may perform, in a prehospital, interhospital or emergency care setting in a hospital, or during the transfer of convalescent or other nonemergency cases, the BLS services set forth in subsection (e), to prevent loss of life or aggravation of physiological or psychological illness or injury. This section does not prohibit an EMT from providing BLS services as a good Samaritan.

(b) Certification.

(1) [To qualify for EMT certification, an individual shall:] The Department will certify as an EMT an individual who meets the following qualifications:

(i) [Successfully complete a basic EMT training course approved by the Department.] Completes an application on a form prescribed by the Department.

(ii) [Successfully complete an EMT practical skills examination developed by the Department and administered by the Department.] Is 16 years of age or older.

(iii) [Successfully complete a written EMT examination developed by the Department and administered by the Department.] Has successfully completed an EMT training course approved by the Department.

(iv) [Possess current CPR certification.] Has successfully completed a written EMT examination prescribed by the Department.

(v) [Be at least 16 years of age or older.] Has successfully completed an EMT practical skills examination prescribed by the Department.

(2) The Department will also certify as an EMT an individual who completes an application on a form prescribed by the Department and who has one of the following:

(i) Permanent certification as an EMT-paramedic under §1003.24(b) (relating to EMT-paramedic) but without medical command authorization under §1003.28 (relating to medical command authorization).

(ii) Permanent recognition as a prehospital registered nurse under §1003.25b (relating to prehospital registered nurse) but without medical command authorization under §1003.28.

(3) Certification granted under paragraph (1) or (2) is valid for 3 years, subject to disciplinary action under section 11(j.1) of the act (35 P.S. §6931(j.1)) and §1003.27 (relating to disciplinary and corrective action).

(c) [Reciprocal certification] Certification by endorsement.

[(1) An individual who possesses EMT certification from another state may qualify for reciprocal certification as an EMT in this Commonwealth. Applications shall be submitted to the regional EMS councils. The Department has the authority to make the final decision on the applications.

(2) Reciprocal certification may be granted to EMTs from states that the Department has formal reciprocity agreements with if:

(i) The applicant is currently certified or licensed in a state with reciprocity agreements with the Commonwealth.

(ii) The applicant successfully completed written and practical exams within 2 1/2 years of application.

(iii) The current certification has an expiration date of more than 6 months from date of application.

(iv) If the current certification remaining is less than 6 months, the applicant shall successfully complete written and practical Pennsylvania EMS certification exams.

(v) The applicant completes the student registration form and a request for reciprocity form provided by the Department. The applicant shall attach a copy of incoming State certification or license to the request for reciprocity form.

(3) Certification may be granted to applicants with certification or National registry from states without formal reciprocity agreements if:

(i) The applicant is currently certified or licensed as an EMT.

(ii) The applicant provides written verification of completion of an EMT-NSC National Standard Curriculum Course.

(iii) The applicant successfully completes Pennsylvania written and practical certification exams.

(iv) The current certification has an expiration date of more than 6 months from date of application.

(4) EMT certification may be granted to applicants currently certified by the military, if:

(i) The applicant provides written verification of successful completion of an EMT-NSC course.

(ii) The applicant successfully completes Pennsylvania written and practical certification exams.

(iii) Current certification has an expiration date of more than 6 months from date of application.

(5) Reciprocal certification may be granted with an expiration date of 3 years from the date the certification was issued by the incoming state.

(6) Pennsylvania residents who have been granted reciprocity in this Commonwealth and currently need recertification shall take the Department's practical and written certification examinations.]

(1) For an individual who is 16 years of age or older and currently certified as an EMT in another state, the Department will endorse the following qualifications as equivalent to those in subsection (b):

(i) Successful completion of EMT training curriculum that meets

or exceeds the standards of the training course prescribed by the Department pursuant to subsection (b)(1)(iii).

(ii) Successful completion of a written examination for EMT certification which is determined by the Department to meet or exceed the standards of the written examination prescribed by the Department pursuant to subsection (b) (1) (iv).

(iii) Successful completion of a practical skills examination for EMT certification which is determined by the Department to meet or exceed the standards of the practical skills examination prescribed by the Department pursuant to subsection (b)(1)(v).

(2) An individual whose EMT certification in another state is expired at the time of application may seek to have the satisfaction of paragraph (1)(i) endorsed as equivalent to the satisfaction of subsection (b)(1)(iii), but shall not be considered by the Department for endorsement of qualifications under paragraph (1)(ii) or (iii), and shall successfully complete the EMT practical skills and written examinations prescribed by the Department after making application for certification through examination.

(3) Certification under this subsection is valid for 3 years. Upon expiration of that certification the individual shall meet the requirements for recertification in subsection (d).

(d) Recertification. An EMT shall apply for recertification between 1 year and 60 days prior to expiration of the EMT's certification from the Department. Failure to apply for recertification in a timely manner may result in the individual not being recertified before the prior certification expires. The Department will recertify as an EMT an individual who meets the following qualifications:

(1) Completes an application on a form prescribed by the Department.

(2) Is or was previously certified as an EMT.

(3) [Files with the Department proof of] Has successfully complet[ion]ed [of] one of the following:

(i) The written and practical EMT recertification examinations

prescribed by the Department.

(ii) The continuing education requirements for EMTs in §1003.29(b) (relating to continuing education requirements).

(e) [EMT instructor certification.] Scope of practice.

[(1) To qualify for EMT instructor certification, an individual shall:

(i) Be 18 years of age or older.

(ii) Successfully complete an EMT instructor course as provided by the Department or possess at least a bachelor's degree or teacher's certification in secondary education.

(iii) Possess current certification as an EMT or EMT-paramedic.

(iv) Possess current certification in CPR.

(v) Possess a minimum of 1 year's experience functioning at the EMT or EMT-paramedic level providing prehospital care.

(vi) Possess demonstrated competence in teaching the didactic and practical skills portions of the curriculum. The Department is responsible for assessing an instructor's competence.

(vii) Possess recommendations from the regional EMS council and an approved training institute that the individual be certified as an instructor.

(2) EMT instructor certification shall expire concurrently with the individual's EMT or EMT-paramedic certification.]

An EMT's scope of practice, pursuant to medical command direction or utilization of the Statewide BLS medical treatment protocols, includes the BLS services which may be performed by a first responder as set forth in §1003.22(e) (relating to first responder) and the following:

(1) Administration to a patient or assisting a patient to administer drugs previously prescribed for that patient, as specified in the Statewide BLS medical treatment protocols.

(2) Transportation of a patient with an indwelling intravenous catheter without medication running.

(3) Other BLS services taught in a basic training program for EMTs

approved by the Department, provided the EMT has received training to perform those services in such a course, in a course which is determined by the Department to meet or exceed the standards of a training program for EMTs preapproved by the Department, or in a course for which an EMT may receive continuing education credit towards recertification, and is able to document such training. The Department will publish in the *Pennsylvania Bulletin*, at least annually, a list of the services in the most recent basic training program for EMTs approved by the Department. If the approved course is not offered by the Department, the Department may exclude from the published list, services taught which the Department determines are not appropriate services to be performed by an EMT.

[(f) *Instructor recertification*

(1) To qualify for recertification as an EMT instructor, an individual shall:

(i) Receive favorable ratings from the Department during annual reviews of the instructor under actual classroom conditions.

(ii) Provide documentation to the Department that the instructor did a minimum of 20 hours of teaching per year.

(iii) Possess current certification as an EMT or an EMT-paramedic.

(iv) Possess current certification in CPR.

(v) Possess recommendations for recertification from the regional EMS council and an approved training institute.

(vi) Complete additional continuing education requirements established and approved by the Department.

(2) EMT instructor recertification shall expire concurrently with the individual's EMT or EMT-paramedic recertification.]

§1003.23a. EMS instructor certification.

(a) *Qualifications for certification.* The Department will issue an EMS

instructor certification to an individual who meets all of the following requirements:

(1) Has completed an application for EMS instructor certification on a form prescribed by the Department.

(2) Is 18 years of age or older.

(3) Has successfully completed an EMS instructor course approved by the Department, or possesses a bachelor's degree in education or a teacher's certification in education.

(4) Has successfully completed an EMT-Basic transition program or update, or has completed an EMT-Basic course.

(5) Possesses current certification as an EMT or EMT-paramedic, or recognition as a health professional.

(6) Possesses current certification in CPR.

(7) Possesses at least one year experience functioning at the EMT, EMT-paramedic, or health professional level providing prehospital care.

(b) *Renewal of Instructor certification.* An EMS instructor certification is valid for three years. The Department will renew an EMS instructor certification for an individual who meets all of the following requirements:

(1) Has completed an application for renewal of an EMS instructor certification on a form prescribed by the Department.

(2) Has demonstrated competence in teaching the didactic and practical skills portions of the curriculum.

(3) Has provided documentation to the Department to establish that he or she conducted at least 20 hours of teaching per year.

(4) Possesses current certification as an EMT or EMT-paramedic, or recognition as a health professional.

(5) Possess current certification in CPR.

(6) Has completed an EMS instructor update program within three years prior to applying for renewal of certification.

§1003.24. EMT-paramedic.

(a) Roles and responsibilities.

(1) An [individual who is certified by the Department as an] EMT-paramedic [and] who has been granted medical command authorization under §1003.28 (relating to medical command authorization), or an individual who is a student in an approved EMT- paramedic training program under the supervision of an approved preceptor, may provide in a prehospital, interhospital or in an emergency care setting in a facility, or during the transfer of convalescent or other nonemergency cases, BLS services which may be performed by an EMT as set forth in §1003.23(a) and (e) (relating to EMT), as well as the ALS services listed in subsection (d) to prevent loss of life or aggravation of physiological or psychological illness or injury. This section does not prohibit an EMT-paramedic from providing EMS as a good Samaritan.

(2) An EMT-paramedic who does not have or chooses not to maintain medical command authorization in accordance with §1003.28 may apply to the Department for certification as an EMT. The rules applicable to certification of an EMT-paramedic as an EMT are in §1003.23(b)(2) [(relating to EMT)]. An EMT-paramedic without medical command authorization who is certified as an EMT may provide only the BLS services within an EMT's scope of practice as set forth in §1003.23(a) and (e) until the EMT-paramedic has regained medical command authorization in accordance with §1003.28. Following loss of medical command authorization, an EMT-paramedic may function as an EMT for the ALS ambulance service under which the EMT-paramedic has lost medical command authorization, for 30 days without securing EMT certification, if approval to do so is granted by the ALS service medical director for that ALS ambulance service.

(b) *Certification.*

(1) [To be certified as an EMT-paramedic, an individual shall] The Department will certify as an EMT-paramedic an individual who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

[(i)] (ii) Possesses current certification as an EMT.

(iii) Is 18 years of age or older.

[(ii)] (iv) Has [S]successfully completed a training course for EMT-paramedics approved by the Department.

[(iii)] (v) Has [S]successfully completed a practical examination of EMT-paramedic skills[, as verified by the medical director of the training program on a form provided by the Department].

[(iv) Possess current CPR certification.]

[(v)] (vi) Has [S]successfully completed a written examination for EMT-paramedics administered by the Department.

[(vi) Be 18 years of age or older.]

[(2) An individual who possesses EMT-paramedic certification from another state or National registry may qualify for EMT-paramedic certification in this Commonwealth by meeting the Department's requirements for reciprocity in §1003.23(c).]

[(3)] (2) [The Department will consider a]An individual certified as an EMT-paramedic [to be] is permanently certified as an EMT-paramedic, subject to disciplinary action under section 11(j.1) of the act (35 P.S. §6931(j.1)) and §1003.27 (relating to disciplinary and corrective action).

[(4)] (3) An EMT-paramedic shall register biennially with the Department on forms supplied by the Department prior to the biennial anniversary date of the EMT-paramedic's certification and shall supply information requested by the Department on the registration form.

[(c) Transition of EMT-paramedic I and EMT-paramedic II certification to EMT-paramedic.

(1) Current certification by the Department as an EMT-paramedic II is equivalent to certification as an EMT-paramedic. After June 30, 1989, EMT-paramedic II certifications will not be issued by the Department. Only

certification as an EMT-paramedic will be issued after June 30, 1989.

(2) Certification as an EMT-paramedic I will not be issued after June 30, 1989. Individuals currently certified as an EMT-paramedic I shall successfully complete additional certification requirements as determined by the Department to bring them up to the level of EMT-paramedic by June 30, 1989, or their certification will revert to the status of an EMT for the remainder of their certification period.]

(c) Certification by endorsement.

(1) For an individual who is 18 years of age or older and who is currently certified in another state as an EMT-paramedic, the Department will endorse the following qualifications as equivalent to those in subsection (b).

(i) Certification as an EMT-paramedic in the other state instead of current certification as an EMT in the Commonwealth.

(ii) Successful completion of EMT-paramedic training curriculum that meets or exceeds the standards of the training course prescribed by the Department pursuant to subsection (b)(1)(iv).

(iii) Successful completion of a written examination for EMT-paramedic certification which is determined by the Department to meet or exceed the standards of the written examination prescribed by the Department pursuant to subsection (b)(1)(vi).

(iv) Successful completion of a practical skills examination for EMT-paramedic certification which is determined by the Department to meet or exceed the standards of the practical skills examination prescribed by the Department pursuant to subsection (b)(1)(v).

(2) An individual whose EMT-paramedic certification in another state is expired at the time of application may seek to have the satisfaction of paragraph (1)(ii) endorsed as equivalent to the satisfaction of subsection (b)(1)(iv), but shall not be considered by the Department for endorsement of qualifications under paragraph (1)(i), (iii) or (iv), and shall successfully complete the EMT-paramedic practical skills and written examinations prescribed by the Department after

making application for certification through examination.

(d) *Scope of practice.* An EMT-paramedic's scope of practice includes the BLS services which may be performed by an EMT as set forth in §1003.23(a) and (e) and the ALS services set forth in this subsection. An EMT-paramedic, with medical command authorization, following the order of a medical command physician, or use of Department approved transfer and medical treatment protocols as authorized by the ALS service medical director, may:

(1) Perform pulmonary ventilation by the use of oral, nasal, endotracheal or tracheostomy intubation.

(2) Insert, in peripheral veins, intravenous catheters, needles or other cannulae-IV lines.

(3) Obtain venous blood samples for analysis, but only for diagnostic and treatment purposes.

(4) Prepare and administer approved medication and solutions by intravenous, intramuscular, subcutaneous, intraosseous, oral, sublingual, topical, inhalation, rectal or endotracheal routes.

(5) Perform defibrillation and synchronized cardioversion.

(6) Perform gastric suction by nasogastric or orogastric intubation.

(7) Insert nasogastric or orogastric tubes.

(8) Visualize the airway by use of the laryngoscope and remove foreign bodies with forceps.

(9) Apply electrodes and monitor cardiac electrical activity including electrocardiograms.

(10) Perform [vagal] Valsalva maneuvers.

(11) Use mechanical cardiopulmonary resuscitation devices.

(12) Assess and manage patients in accordance with the EMT-paramedic training curriculum approved by the Department.

(13) Perform thoracic decompression.

(14) Perform cricothyrotomy and pulmonary ventilation.

(15) Perform central venous and intraosseous cannulation.

(16) Perform external trans[thoracic]cutaneous pacing.

(17) Perform urinary catheterization.

(18) Access central venous lines and subcutaneous indwelling catheters.

(19) Perform other ALS services [authorized by the Department-approved regional EMS council transfer and medical treatment protocols.] taught in a training course for EMT-paramedics approved by the Department, provided the EMT-paramedic has received training to perform those services in such a course, in a course which is determined by the Department to meet or exceed the standards of a training course for EMT-paramedics preapproved by the Department, or in a course for which an EMT-paramedic may receive continuing education credit towards qualifying for medical command authorization, and is able to document such training. The Department will publish, at least annually, a list of the ALS services taught in the most recent training course for EMT-paramedics approved by the Department. If the approved course is not offered by the Department, the Department may exclude from the published list, services taught which the Department determines are not appropriate services to be performed by an EMT-paramedic.

§1003.25. (Reserved).

§1003.25a. Health professional physician.

[(a) *Basic qualifications.*] Physicians who have education and continuing education in ALS services and prehospital care may [participate in EMS teams] function as a member of the crew on an ambulance as a health professional[s]. This section does not prohibit a health professional physician from providing EMS as permitted under 42 Pa.C.S. §8331 (relating to medical good Samaritan civil immunity).

[(b) *Minimum qualifications* At a minimum, a health professional physician

shall:

(1) Be a practicing physician.

(2) Possess valid CPR certification.

(3) Possess valid ACLS certification.

(4) Possess current certification as an EMT-paramedic, or successfully complete a prehospital health professional training program approved by the Department and a practical skills evaluation and written examination administered by the Department.

(c) *Recognition of current practitioners who are physicians.* A 1-year grace period after the approval of a prehospital physician course will permit an individual currently working in the prehospital setting to challenge the practical or written portion, or both, of the physician prehospital exam format under the following conditions:

(1) The physician shall take written and practical prehospital physician exams and possess:

(i) A valid license to practice in this Commonwealth as a Doctor of Medicine or Doctor of Osteopathy.

(ii) Evidence of participation in an educational program sponsored by a hospital or regional training institute intended to provide the physician with the knowledge and skills needed to provide an advanced level of prehospital care, including physical assessment, immobilization and stabilization, patient extrication, airway management, EKG and rhythm interpretation and pharmacology.

(iii) A letter of support from a director of a medical command facility specific to challenging the exams.

(2) The physician need take only the practical prehospital physician exam and possess:

(i) A valid license to practice in this Commonwealth as a Doctor of Medicine or Doctor of Osteopathy.

(ii) Evidence of participation in an educational program

sponsored by a hospital or regional training institute intended to provide the physician with the knowledge and skills needed to provide an advanced level of prehospital care, including physical assessment, immobilization and stabilization, patient extrication, airway management, EKG and rhythm interpretation and pharmacology.

(iii) Board certification in an appropriate specialty or a residency in an emergency medicine residency program or currently advanced cardiac life support and advanced trauma life support course certified.

(iv) A letter of support from a director of a medical command facility specific to challenging the exams.

(d) *Health professionals with specialty transport teams.* For the purposes of §1005.10(d) (relating to licensure standards), a physician may function as a health professional for specialty transport situations when operating under institutional policies and procedures approved by the Department.]

§1003.25b. Prehospital registered nurse.

(a) Roles and responsibilities.

(1) A prehospital registered nurse who has medical command authorization under §1003.28 (relating to medical command authorization) may provide the ALS services in §1003.24(d) (relating to EMT-paramedic) and those listed at subsection (c) in addition to the BLS services in §1003.23(a) and (e) (relating to EMT) to respond to the perceived needs of an individual for immediate medical care in an emergency. This section does not prohibit a prehospital registered nurse from providing EMS as permitted under 42 Pa.C.S. §8331 (relating to medical good Samaritan civil immunity).

(2) A prehospital registered nurse who does not have or chooses not to maintain medical command authorization may apply to the Department for recognition as an EMT. The rules applicable to certification of a prehospital registered nurse as an EMT are set forth in §1003.23(b)(2). Following loss of

medical command authorization, a prehospital registered nurse may function as an EMT for the ALS ambulance service under which the prehospital registered nurse has lost medical command authorization, for 30 days without securing EMT certification, if approval to do so is granted by the ALS service medical director for that ALS ambulance service.

(b) Recognition of a prehospital registered nurse.

(1) The Department will recognize as a prehospital registered nurse a [licensed] registered nurse who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Is 18 years of age or older.

(iii) Has successfully completed the American Heart Association or American Red Cross basic cardiac life support training program and the [American Heart Association advanced cardiac life support training program] ACLS course, or other programs determined by the Department to meet or exceed the standards of the specified programs.

(iv) Has successfully completed one of the following:

(A) The Pennsylvania prehospital registered nurse curriculum adopted by the Department.

(B) A knowledge and skills assessment process adopted by the Department.

(v) Has successfully completed the written ALS examination for prehospital registered nurses approved by the Department.

(vi) Has successfully completed the EMT practical skills examination.

(2) A [licensed] registered nurse who received recognition as a health professional registered nurse under the voluntary health professional registered nurse recognition program conducted by the Department prior to September 2, 1995, will be deemed to have Department recognition as a prehospital registered nurse.

(3) Department recognition of a prehospital registered nurse [under paragraphs (1) and (2)] pursuant to this section [will be] is permanent subject to disciplinary action [under] pursuant to §11(j.1) of the act (35 P.S. §6931(j.1)) and §1003.27 (relating to disciplinary and corrective action).

(4) A prehospital registered nurse shall register biennially with the Department on forms supplied by the Department prior to the biennial anniversary date of the prehospital registered nurse's recognition and shall supply information requested on the registration form.

(c) *Scope of practice.* A prehospital registered nurse with medical command authorization may perform, in addition to those services within an EMT-paramedic's scope of practice, [the following services:

(1) Those] other ALS services authorized by The Professional Nursing Law (63 P.S. §§221--225.5)[.]

[(2) Other ALS services authorized by the Department-approved regional EMS council transfer and medical treatment protocols.

(3) Other ALS services authorized by medical command in the case of a prehospital registered nurse who functions on an air ambulance service], when authorized by a medical command physician through either on line medical command or standing treatment protocols.

(d) Recognition by endorsement.

(1) The Department will grant recognition as a prehospital registered nurse to an individual who has served in a similar capacity in another state and who meets the following qualifications:

(i) Completes an application on a form prescribed by the Department.

(ii) Is 18 years of age or older.

(iii) Has successfully completed the American Heart Association or the American Red Cross basic life support training program and the ACLS course, or other programs determined by the Department to meet or exceed the standards of the specified programs.

(iv) Is licensed as a registered nurse in both this Commonwealth and another state.

(v) Has successfully completed either of the following:

(A) The written ALS examination for prehospital registered nurses approved by the Department and the EMT practical skills examination.

(B) Written and practical skills examinations determined by the Department to meet or exceed the examinations approved by the Department.

(vi) Has successfully completed one of the following:

(A) The Pennsylvania prehospital registered nurse curriculum adopted by the Department.

(B) A knowledge and skills assessment process adopted by the Department.

(C) Curriculum or a knowledge and skills assessment process, which is determined by the Department to meet or exceed the standards adopted by the Department.

§1003.26. Rescue personnel.

(a) *Basic rescue practices technician.*

(1) *Roles and responsibilities.* A [certified] basic rescue practices technician is [authorized] an individual certified by the Department as possessing the training and skills to perform rescue skills in accordance with the basic rescue practices course approved by the Department. A [certified] basic rescue practices technician utilizes basic tools and equipment of the rescue service [and is responsible for employing these tools, equipment and techniques] to perform a safe and efficient rescue operation.

(2) *Training programs.* Basic rescue practices technician training programs will be approved by the Department.

(3) *Minimum qualifications.* A basic rescue practices technician shall

successfully complete a training program for basic rescue practices approved by the Department and shall successfully complete a written basic rescue practices test administered by the Department.

(b) *Basic vehicle rescue technician.*

(1) *Roles and responsibilities.* A [certified] basic vehicle rescue technician is [authorized] an individual certified by the Department as possessing the training and skills to perform rescue skills in accordance with the basic vehicle rescue course approved by the Department [which]. That program provides the student with the knowledge and skills necessary to achieve the rescue of persons involved in automobile accidents [on highways].

(2) *Training programs.* Basic vehicle rescue technician training programs will be approved by the Department.

(3) *Minimum qualifications.* A basic vehicle rescue technician shall complete a training program for basic vehicle rescue approved by the Department, and shall successfully complete a written examination for basic vehicle rescue developed by the Department and administered by the Department.

(c) *Special[ized] vehicle rescue technician.*

(1) *Roles and responsibilities.* A [person certified in] special[ized] vehicle rescue technician is an individual certified by the Department as possessing the training and skills [training is authorized] to perform rescues [skills] in accordance with the specialized rescue training course approved by the Department.

(2) *Training programs.* Specialized rescue training programs will be approved by the Department.

(3) *Minimum qualifications.* An individual shall complete a training program approved by the Department for a specific level of specialized vehicle rescue performance, and also shall successfully complete a written examination developed by the Department and administered by the Department.

(d) *Rescue instructor* [*roles and responsibilities.*

(1) Rescue instructors shall:

(i) Follow the prescribed course of instruction in leading the student to mastery of unit's objectives and finally to mastery and accomplishment of successfully reaching the course objective.

(ii) Assure that teaching aids are present and in operating condition.

(iii) Assure that tools, equipment and support materials are present and in operating condition.

(iv) Set -up the classroom facility to permit a comfortable, yet successful, learning environment.

(v) Assure that field training facilities are sufficient to meet the needs of the practice phase of the training program.

(vi) Obtain and prepare classroom materials and exercises which reflect local resources, policies and practices.

(vii) Keep discussion oriented toward basic rescue practices.

(viii) Prepare practice and remedial activities, as required, to permit students to meet stated objectives.

(ix) Assign responsibilities to assistant instructors.

(x) Supervise assistant instructors.

(xi) Monitor and evaluate student and assistant instructor attendance, and performance.

(xii) Maintain records of student and instructor attendance, performance evaluation and knowledge levels.

(xiii) Provide recommendations for course improvement.

(2) At a minimum, rescue instructors shall:

(i) Be certified as an EMT by the Department, and be certified in the fundamentals of fire fighting.

(ii) Successfully complete a course of instruction in the techniques and philosophy of teaching. One of the following shall be submitted as proof of completion of this requirement:

(A) A baccalaureate degree with an education major.

(B) State certification as an EMT-instructor.

(C) State certification as a fire service instructor.

(iii) Successfully complete the Basic Rescue Practices Training Program which they intend to teach.

(iv) Be certified as a rescue instructor by the Department.

(v) Be able to demonstrate their ability to operate every tool and piece of equipment identified on the minimum equipment list in a manner above the average person's ability to perform.

(vi) Agree to actively participate in the presentation of at least one certified basic rescue course per year in order to maintain their instructor certification.

(3) The Department will give special consideration to competent instructors who do not meet the requirements in paragraph (2)(ii)(A)-(C). The candidate shall submit a letter to the Department of Health, Division of Emergency Medical Services, Post Office Box 90, Harrisburg, Pennsylvania 17108.]--The Department will develop a program providing for the certification of rescue instructors. Courses that seek Department approval as a rescue training course shall be taught by certified rescue instructors.

(e) The rescue technician certifications issued by the Department pursuant to this section do not constitute a legal prerequisite to performing rescues. The rescue instructor certifications issued by the Department pursuant to this section do not constitute a legal prerequisite to serving as a rescue instructor in programs other than rescue training courses approved by the Department. The Department approves the rescue programs and issues the certifications referenced within this section to promote the Statewide EMS system having an adequate number of personnel with sufficient training and skills to perform rescues.

§1003.27. Disciplinary and corrective action.

(a) The Department may, upon investigation, hearing and disposition, impose upon prehospital personnel who are certified or recognized by the Department one or more of the disciplinary or corrective measures in subsection (c) for one or more of the following reasons:

(1) Demonstrated incompetence to provide adequate emergency medical services.

(2) Deceptive or fraudulent procurement or misrepresentation of certification or recognition credentials.

(3) Willful or negligent practice beyond the scope of certification or recognition authorization.

(4) Abuse or abandonment of a patient.

(5) The rendering of services while under the influence of alcohol or illegal drugs.

(6) The operation of an emergency vehicle in a reckless manner or while under the influence of illegal drugs or alcohol.

(7) Disclosure of medical or other information if prohibited by Federal or State law.

(8) Willful preparation or filing of false medical reports or records, or the inducement of others to do so.

(9) Destruction of medical records required to be maintained.

(10) Refusal to render emergency medical care because of a patient's race, sex, creed, National origin, sexual preference, age, handicap, medical problem or financial inability to pay.

(11) Failure to comply with Department-approved regional EMS council transfer and medical treatment protocols.

(12) Failure to comply with ambulance [trip] response reporting requirements as established by the Department.

(13) Failure to meet recertification requirements.

(14) Conviction of a felony or crime involving moral turpitude. Conviction includes a judgment of guilt, a plea of guilty or a plea of nolo

contendere.

(15) Conviction of a misdemeanor which relates to the practice or the profession of the prehospital personnel practitioner. Conviction is a judgment of guilt.

(16) A willful or consistent pattern of failure to complete details on a patient's medical record.

(17) Misuse or misappropriation of drugs or medication.

(18) Having a certification or other authorization to practice a health care profession or occupation revoked, suspended or subjected to disciplinary sanction.

(19) Failure to comply with skill maintenance requirements established by the Department.

(20) Violating a duty imposed by the act, this part or an order of the Department previously entered in a disciplinary proceeding.

(21) Other reasons as determined by the Department which pose a threat to the health and safety of the public.

(b) It is the duty of all prehospital personnel to report to the Department, within 30 days, a misdemeanor or felony conviction, or a revocation, suspension or other disciplinary sanction of a certificate or other authorization to practice a health care profession or occupation.

(c) If disciplinary action is appropriate for one of the reasons listed in subsection (a), the Department may:

(1) Deny an application for certification or recognition.

(2) Administer a written reprimand with or without probation.

(3) Revoke, suspend, limit or otherwise restrict the certification or recognition.

(4) Require the person to take refresher educational courses.

(5) Stay enforcement of a suspension and place the individual on probation with the right to vacate the probationary order for noncompliance.

(d) The Department will conduct all aspects of the disciplinary process and

any hearing that may be held in accordance with 1 Pa. Code Part II (relating to general rules of administrative practice and procedure). A revocation or suspension of certification or recognition may be appealed to the Commonwealth Court under 2 Pa.C.S. §§501-508 and 701-704 (relating to [a]Administrative [a]Agency [l]Law).

§1003.28. Medical command authorization.

(a) *Authority to grant medical command.* The ALS service medical director has the authority to grant, deny, or restrict as provided in subsection (c)(3), medical command authorization to an EMT-paramedic or prehospital registered nurse who seeks to provide EMS on behalf of the ALS ambulance service. The ALS service medical director shall document the medical command authorization decision and how that decision was made. The decision of the ALS service medical director shall affect the medical command authorization status of the EMT-paramedic or prehospital registered nurse for that ALS ambulance service only.

(b) *Prerequisites to initial determination regarding medical command authorization.*

(1) Prior to making the initial determination whether to grant or deny medical command authorization, the ALS service medical director shall:

(i) Require the individual seeking medical command authorization to complete an application for medical command authorization on a form prescribed by the Department.

(ii) Verify with the Department the individual's certification or recognition status.

(iii) Inquire of the Department whether disciplinary action under section 11(j.1) of the act (35 P.S. §6931(j.1)) and §1003.27 (relating to disciplinary and corrective action) has been or is currently being imposed against the individual.

(2) The ALS service medical director shall deny medical command authorization to an individual who is not certified or recognized by the Department, who is currently subject to a disciplinary or corrective measure imposed by the Department which prevents the individual from having medical command authorization, or who has not complied with the applicable continuing education requirements in §1003.29 (relating to continuing education requirements).

(3) Before the ALS service medical director may grant medical command authorization to an individual, the ALS service medical director shall verify that the individual can competently perform each of the services set forth [in] within the [individual's applicable] scope of practice authorized by the individuals' certification or recognition, which is also permitted by the medical treatment protocols in the region or regions in which ambulances of the ALS ambulance service, out of which the individual will function, are stationed. If the individual had not previously been granted medical command authorization for any ALS ambulance service in this Commonwealth, the ALS service medical director shall [directly observe] determine the individual's [performance of each ALS service set forth in the individual's applicable scope of practice] competence to perform those services by direct observation or by consulting with a physician, EMT-paramedic or prehospital registered nurse who has directly observed the individual's performance of those services, and who the ALS service medical director has determined to be qualified to make the assessment. If the individual had previously been granted medical command authorization, the ALS service medical director shall verify that the individual can competently perform each [ALS service set forth in the individual's applicable scope of practice] of those services by either directly observing the individual's performance of those services; or by consulting with a physician, EMT-paramedic or prehospital registered nurse who has directly observed the individual's performance of those services, and who the ALS service medical director has determined to be qualified to make the assessment; or doing the following for services not directly

observed:

(i) Consulting with one or more medical command physicians who have given the individual medical command.

(ii) Consulting with emergency department physicians who have received patients to whom the individual has provided prehospital emergency care.

(iii) Performing a medical audit of records of services provided by the individual seeking medical command authorization, for patients attended to by that individual for the ALS ambulance for which the ALS service medical director is making the medical command authorization decision.

(iv) Consulting with one or more ALS service medical directors who has granted, denied or restricted the individual's medical command status.

(4) If the ALS service medical director determines that the individual applying for medical command authorization cannot competently perform [the ALS services within that individual's scope of practice] one or more of those services, the ALS service medical director shall either deny, or restrict as provided in subsection (c)(3), the individual's medical command authorization in a written document provided to the individual.

(c) *Review of medical command authorization.* At least annually, and more often as circumstances warrant, the ALS service medical director shall review the medical command authorization status of each EMT-paramedic and prehospital registered nurse providing services on behalf of the ALS ambulance service. In reviewing medical command authorization, the ALS service medical director shall ensure that the individual has completed or is completing the applicable continuing education requirements in §1003.29 and has demonstrated competence, as verified by the ALS service medical director, in performing each of the [skills set forth in the individual's scope of practice] services that fall within the scope of the individual's medical command authorization. The ALS service medical director, upon review of medical command authorization, may:

(1) Renew medical command authorization.

(2) Renew medical command authorization and require continuing education courses in any field the ALS service medical director deems appropriate. The ALS service medical director may require an individual to secure more continuing education credit than generally required for personnel operating under medical command authorization for the ALS ambulance service, only if the ALS service medical director determines that the individual does not demonstrate sufficient competence in performing a service, the continuing education is prescribed to address that deficiency, and the number of continuing education hours generally required are not sufficient to provide the education the individual needs to remedy the problem.

[(3) Require completion of specified continuing education courses as a prerequisite to renewal of medical command authorization.

(4)] (3) Restrict [the scope of practice under] medical command authorization, providing the restriction does not preclude the individual from performing the services specified within the scope of the individual's certification or recognition as permitted by the medical treatment protocols for the region. This permits imposing a restriction such as requiring on scene supervision when the individual performs a specified service or services, or permitting a specified service or services to be performed only when the individual is receiving on-line medical command.

[(5)] (4) Withdraw medical command authorization.

(d) *Appeals to the regional EMS medical director.* An individual whose medical command authorization has been denied [or restricted] by the ALS service medical director may appeal the decision within 14 days to the regional EMS medical director. The individual's appeal shall be in writing and shall specify the reasons the individual disagrees with the decision of the ALS service medical director. The regional EMS medical director shall conduct a hearing. If the regional EMS medical director is unable to conduct a fair hearing due to receiving prejudicial information prior to the hearing, or for any other reason, the regional EMS council shall arrange for the regional EMS medical director of

another region to conduct the hearing. At the hearing, the ALS service medical director shall have the burden to proceed and offer testimony and other evidence in support of the ALS service medical director's decision. The individual shall also have an opportunity to present testimony and other evidence in support of the individual's position. Both parties shall have an opportunity to cross-examine opposing witnesses and to submit oral and written position statements. The regional EMS medical director may give the parties up to 5 additional days following the hearing to submit written position statements. The regional EMS medical director will issue a written decision affirming, reversing or modifying the ALS service medical director's decision within 14 days [of] after the hearing or within 14 days [of] after the submission of post hearing position statements, if they are filed. The regional EMS medical director's written decision shall contain the regional EMS medical director's findings and conclusions. If the ALS service medical director fails to appear at the hearing, the regional EMS medical director shall reverse the ALS service medical director's decision. If the individual fails to appear at the hearing, the regional EMS medical director shall make a determination upon the evidence presented and either affirm, reverse or modify the decision of the ALS service medical director. The burden of proof is a preponderance of the evidence.

(e) *Appeals to the Department.* If either party is dissatisfied with the decision of the regional EMS medical director with regard to medical command authorization, that party shall have the right of immediate appeal to the Department. The party appealing the regional EMS medical director's decision shall submit a written statement to the Department specifying the reasons for the party's objections to the regional EMS medical director's decision within 14 days [of] after that decision. The other party shall have 14 days to respond. The Department will review the record before the regional EMS medical director, and if deemed advisable by the Department shall hear argument and additional evidence. As soon as practicable, the Department, will issue a final decision containing findings of fact and conclusions of law which affirms, reverses or

modifies the regional EMS medical director's decision.

(f) *Scope of appeals.* Appeals under this section shall be confined to a review and determination of whether, at the time of the assessment conducted by the ALS service medical director, the individual possessed the competence to perform [skills for which the individual was denied medical command authorization] all services within the scope of the individual's medical command authorization for the ambulance service.

(g) *Service; determination of time period.* Each party shall serve the other with any document the party files with a regional EMS medical director or the Department. In determining the time in which a document is to be filed pursuant to this section, time begins to run for the parties when the document is mailed, and time begins to run for a regional EMS medical director when the document is received by the regional EMS medical director.

§1003.29. Continuing education requirements.

(a) *First responders.* A first responder who elects to qualify for recertification by fulfilling continuing education requirements shall, prior to the expiration of the 3-year certification period, [attend] successfully complete the following:

(1) Sixteen hours of instruction [provided by a continuing education sponsor] in subjects related to the scope of practice of a first responder as set forth in §1003.22(a) and (e) (relating to first responder) and which have been approved by the Department for continuing education credit. During the first full certification period the first responder begins following **[effective date of regulations]**, at least eight of those credits shall be in medical and trauma education.

(2) A CPR course [for adult, child and infant sponsored by the American Heart Association, the American Red Cross or another CPR program determined by the Department to meet or exceed the standards of the specified

programs] completed or taught biennially.

(b) *EMTs.* An EMT who elects to qualify for recertification by fulfilling continuing education requirements shall, prior to the expiration of the 3-year certification period, [attend] successfully complete the following:

(1) Twenty-four hours of instruction [provided by a continuing education sponsor] in subjects related to the scope of practice of an EMT as set forth in §1003.23(a) and (e) (relating to EMT) and which have been approved by the Department for continuing education credit. During the first full certification period the EMT begins following **[effective date of regulations]**, at least twelve of those credits shall be in medical and trauma education.

(2) A CPR course [for adult, child and infant sponsored by the American Heart Association, the American Red Cross or another CPR program determined by the Department to meet or exceed the standards of the specified programs] completed or taught biennially.

(c) *EMT-paramedics.* To be eligible to receive and retain medical command authorization, an EMT-paramedic shall [attend] successfully complete in each calendar year, 18 hours of instruction [provided by a continuing education sponsor] in subjects related to the scope of practice of an EMT-paramedic as set forth in §1003.24(a) and (d) (relating to EMT-paramedic) and which have been approved by the Department for continuing education credit, and shall biennially attend or teach a CPR course [for adult, child and infant sponsored by the American Heart Association, the American Red Cross or another CPR program determined by the Department to meet or exceed the standards of the specified programs]. Beginning in 1999, at least nine of the eighteen hours of instruction shall be in medical and trauma education. In the initial year of certification, the EMT-paramedic's continuing education requirements, to secure renewal of medical command authorization for the following year, shall be prorated based upon the month the certification was secured.

(d) *Prehospital registered nurses.* To be eligible to receive and retain medical command authorization, a prehospital registered nurse shall [attend]

successfully complete in each calendar year, 18 hours of instruction [provided by a continuing education sponsor] in subjects related to the scope of practice of a prehospital registered nurse as set forth in §1003.25b(a) and (c) (relating to prehospital registered nurse) and which have been approved by the Department for continuing education credit, and shall attend or teach biennially a CPR course [for adult, child and infant sponsored by the American Heart Association, the American Red Cross or another CPR program determined by the Department to meet or exceed the standards of the specified programs]. Beginning in 1999, at least nine of the eighteen hours of instruction shall be in medical and trauma education. In the initial year of recognition, the prehospital registered nurse's continuing education requirements, to secure renewal of medical command authorization for the following year, shall be prorated based upon the month the recognition was secured.

(e) *[Continuing education credit for instruction.* Prehospital personnel may also accrue hours to be credited to the individual's continuing education requirements equivalent to the number of hours the individual is an instructor in a continuing education course offered by a continuing education sponsor, or a course that satisfies requirements for initial certification or recognition of prehospital personnel conducted by an accredited training institute for prehospital personnel. EMT-paramedics and prehospital registered nurses may secure no more than 6 hours of continuing education credit in a calendar year for serving as an instructor in courses for EMTs or first responders.] This section does not prohibit an ambulance service from requiring prehospital personnel to satisfy continuing education requirements it may choose to impose as a condition of employment, provided that the ambulance service may not do the following:

(1) Excuse a prehospital practitioner from meeting continuing education requirements imposed by this section.

(2) Establish individual continuing education requirements for the EMT-paramedics or prehospital registered nurses staffing the ambulance

service, except as authorized by §1003.28(c)(2) (relating to medical command authorization).

[(f) *Continuing education credit through endorsement.* Prehospital personnel who attend courses offered by any organization or agency with National or state accreditation to provide continuing education may apply to the Department to receive credit for these courses. The individual shall have the burden of demonstrating to the Department that these courses meet standards equivalent to those standards imposed by this part.]

§1003.30. Accreditation of sponsors of continuing education.

(a) Entities and institutions may apply for accreditation as a continuing education sponsor by submitting to the Department an application [on] in a format [supplied] prescribed by the Department. The applicant shall supply all information requested [on] in the application. The Department will grant accreditation to an applicant for accreditation as a continuing education sponsor [who] if the applicant satisfies the Department that the courses the applicant will offer will meet the following minimum standards:

(1) The courses shall be of intellectual and practical content.

(2) The courses shall contribute directly to the professional competence, skills and education of prehospital personnel.

(3) The course instructors shall possess the necessary practical and academic skills to conduct the course effectively.

(4) Course materials shall be well written, carefully prepared, readable and distributed to attendees at or before the time the course is offered whenever practical.

(5) The courses shall be presented by a qualified responsible instructor in a suitable setting devoted to the educational purpose of the course.

[(6) The course shall be open to all prehospital personnel interested in

the subject matter.]

(b) Accreditation of the continuing education sponsor shall be effective for 3 calendar years.

(c) At least [30] 90 days prior to expiration of the 3-year accreditation period, a continuing education sponsor shall apply to the Department for renewal of the sponsor's accreditation. The Department will renew the sponsor's accreditation if the sponsor meets all of the following requirements:

(1) The sponsor has presented, within the preceding 3 years, at least five separate continuing education courses which met the minimum standards set forth in subsection (a).

(2) The sponsor establishes to the Department's satisfaction that future courses to be offered by the sponsor will meet the minimum standards in subsection (a).

(3) The sponsor has satisfied its responsibilities under §1003.32 (relating to responsibilities of continuing education sponsors).

(d) If the Department deems that the continuing education sponsor has demonstrated a history of understanding and compliance with the regulatory standards for providing continuing education to prehospital personnel, the Department may apprise the continuing education sponsor that its accreditation constitutes prior approval of continuing education courses offered under this chapter which are presented in a classroom setting, and permit the continuing education sponsor to assign the number of credit hours for such a course, based upon the criteria in §1003.31(a) (relating to credit for continuing education).

§1003.31. Credit for continuing education.

(a) *Credit hour.* A prehospital practitioner shall receive one hour credit for each 60 minutes of instruction presented in a classroom setting by a continuing education sponsor. No credit shall be received if attendance or other participation in the course is not adequate to meet the educational objectives of

the course as determined by the course sponsor. No credit shall be received for other than 30 or 60-minute units of instruction, however the course must be at least 60 minutes. For completing a continuing education course that is not presented in a classroom setting, or that is not presented by a continuing education sponsor, the prehospital practitioner shall receive the number of credit hours assigned by the Department to the course.

(b) *Course completion.* A prehospital practitioner shall receive no credit for a continuing education course not completed, as evidenced by satisfaction of the check-in/check-out process for a course presented in a classroom setting by a continuing education sponsor, which reflects that the prehospital practitioner met the continuing education attendance requirement for receiving credit, and the continuing education sponsor's report to the Department verifying that the prehospital practitioner has completed the course. The course shall also not be considered completed if the prehospital practitioner does not satisfy other course completion requirements imposed by this chapter and the continuing education sponsor.

(c) *Continuing education credit for instruction.* A prehospital practitioner shall receive credit equal to the number of hours served as an instructor in a continuing education course offered by a continuing education sponsor, or in a course that satisfies requirements for initial certification or recognition of a prehospital practitioner conducted by a training institute for prehospital personnel accredited by the Department.

(d) *Continuing education credit through endorsement.* A prehospital practitioner who attends or teaches a course offered by an organization with national or state accreditation to provide education may apply to the Department to receive credit for the course. The prehospital practitioner shall have the burden of demonstrating to the Department that the course meets standards substantially equivalent to the standards imposed in this chapter.

(e) *Continuing education credit assigned to courses not conducted by a continuing education sponsor.* If a course is offered by an organization with

national or state accreditation to provide education, which is not a continuing education sponsor, the Department will assign credit to the course, including the possibility of no credit or partial credit, based upon considerations of whether the course bears entirely upon appropriate subject matter and whether the method of presenting the course meets standards substantially equivalent to those prescribed in this chapter.

(f) *Continuing education credit assigned to self-study courses.* Credit may be sought from the Department for a self-study continuing education course. The prehospital practitioner shall submit an application to the Department to approve the self-study course for credit prior to commencing the course and shall supply the Department with the materials the Department requests to conduct the evaluation. The Department will assign credit to the course based upon considerations of whether the course addresses appropriate subject matter and whether the method of completing the course meets standards substantially equivalent to those prescribed in this chapter. The Department may require modifications to the proposed self-study as a precondition to approving it for credit.

(g) *Continuing education credit assigned to courses not presented in a classroom setting.* A prehospital practitioner shall be awarded credit for completing a course without the prehospital practitioner physically attending the course in a classroom setting, provided the course has been approved by the Department for credit when presented in that manner.

(h) *Reporting continuing education credits to prehospital personnel.* A record of the continuing education credits received by prehospital personnel shall be maintained in a statewide registry. A report of the continuing education accumulated shall be provided annually to first responders and EMTs, and semi-annually to EMT-paramedics and prehospital registered nurses at the mailing address on record with the Department.

(i) *Resolution of discrepancies.* It is the responsibility of the prehospital practitioner to review the report of continuing education credits and to notify the

appropriate regional EMS council of any discrepancy within 30 days after the report is mailed. The Department will resolve all discrepancies between the number of continuing education credits reported and the number of continuing education credits a prehospital practitioner alleges to have earned, which are not resolved by the regional EMS council.

§1003.32. Responsibilities of continuing education sponsors.

(a) *Record of attendance.* A continuing education sponsor shall maintain a record of attendance for a course presented in a classroom setting by maintaining a check-in/check-out process approved by the Department, and shall assign at least one person to ensure that all individuals attending the course check in when entering and check out when leaving. If an individual enters a course after the starting time, or leaves a course before the finishing time, the assigned person shall ensure that the time of arrival or departure is recorded for the individual.

(b) *Reporting attendance.* A continuing education sponsor shall report to the Department, in the manner and format prescribed by the Department, attendance at each continuing education course presented in a classroom setting within 10 days after the course has been presented.

(c) *Course evaluation.* A continuing education sponsor shall develop and implement methods to evaluate its course offerings to determine their effectiveness. The methods of evaluation shall include providing a course evaluation form to each person who attends a course.

(d) *Record retention.* The continuing education sponsor shall retain for each course it presents, the completed course evaluation forms and the check-in/check-out record for a course presented in a classroom setting. If the continuing education sponsor has received Department approval to assign credit to a course pursuant to §1003.30(d) (relating to accreditation of sponsors of continuing education), the retained records shall also include course materials

used, a record of the course instructor's qualifications, the course instructor's lesson plans, and examinations if applicable. These records shall be retained for at least four years from the presentation of the course.

(e) *Providing records.* A continuing education sponsor shall promptly provide the Department with complete and accurate records relating to the course as requested by the Department.

(f) *Course not presented in a classroom setting.* A continuing education sponsor shall be exempt from the requirements of subsections (a) and (b) for a course which is not presented in a classroom setting, if the course is approved by the Department for credit when presented in that manner. When presenting the course to the Department for approval for credit, the continuing education sponsor shall present a procedure for monitoring, confirming and reporting prehospital practitioner participation in a manner that achieves the purposes of subsections (a) and (b).

(g) *Monitoring responsibilities.* A continuing education sponsor shall ensure that a course was presented in a manner that met all of the educational objectives for the course, and shall determine whether each prehospital practitioner who enrolled in the course met the requirements of this chapter and the continuing education sponsor to receive credit for completing the course.

(h) *Course completion.* A continuing education sponsor shall report to the Department, in a manner and format prescribed by the Department, completion of a course by a prehospital practitioner who completes the course, and shall identify to the Department a prehospital practitioner who seeks credit for a course but who did not meet the requirements of the continuing education sponsor or this chapter to receive continuing education credit. The continuing education sponsor shall also provide a prehospital practitioner who completes a course with a document certifying completion of the course.

§1003.33. Advertising.

(a) A continuing education sponsor may advertise a course as a continuing education course in a manner that states or suggests that the course meets the requirements of this chapter only if the course has been approved by the Department or is deemed approved pursuant to §1003.30(d) (relating to accreditation of sponsors of continuing education).

(b) When a course has been approved for continuing education credit, the continuing education sponsor shall announce, in its brochures or registration materials: this course has been approved by the Pennsylvania Department of Health for [**the approved number of hours**] of continuing education credit for [the type of prehospital practitioner to which the course applies].

(c) If a continuing education sponsor advertises that it has applied to the Department to secure continuing education credit for a course, prior to presenting the course it shall disclose to all enrollees whether the course has been approved or disapproved for credit.

§1003.34. Withdrawal of accreditation or course approval.

If the continuing education sponsor fails to satisfy the requirements of this chapter, the Department may:

(1) Withdraw its accreditation.

(2) Downgrade its accreditation status to provisional accreditation, subject to withdrawal if deficiencies are not resolved within a time period prescribed by the Department.

(3) Withdraw approval of a continuing education course applicable to any future presentation of the course.

Subchapter C. [AIR AMBULANCE PERSONNEL] (Reserved).

Sec.

1003.41. [Air ambulance medical director.] **(Reserved).**

1003.42. [Air ambulance medical crew members.] **(Reserved).**

1003.43. [Air ambulance pilot.] **(Reserved).**

1003.44. [Air ambulance communications specialist.] **(Reserved).**

§1003.41. [Air ambulance medical director.] (Reserved).

[(a) *Roles and responsibilities.* An air ambulance medical director is responsible for the following:

(1) Providing medical guidance and advice to the air ambulance service personnel.

(2) Participating in training of medical flight crew members.

(3) Granting or denying medical command authorization in accordance with §1003.28 (relating to medical command authorization) to medical flight crew members who require the authorization.

(4) Performing medical audits of patient care provided by the air ambulance service's medical flight crew members.

(b) *Minimum qualifications.* If the air ambulance medical director is not a medical command physician, the air ambulance medical director shall:

(1) Possess the minimum qualifications for a medical command physician in §1003.4 (b) (1)--(5) (relating to medical command physician).

(2) Have experience in the base station radio direction of prehospital personnel.

(3) Have knowledge of altitude physiology and of potential medical

complications which may arise during transport of a patient by air ambulance.

(4) Have knowledge of air craft safety and the capabilities and limitations of the aircraft used.

(5) Have knowledge regarding the application, use, maintenance and hazards of routine or special medical equipment used during transport of patients by the air ambulance service.

(6) Successfully complete Parts A and B of the Medical Command Base Station Course adopted by the Department.]

§1003.42. [Air ambulance medical crew members.] (Reserved).

[(a) *Roles and responsibilities.* The air ambulance medical air crew members shall have the following responsibilities:

(1) To assure that equipment/supplies that are required for an air ambulance flight are on the aircraft and in working order prior to takeoff for patient transport.

(2) To provide medical care and intervention according to direct medical command or written protocols/standing orders.

(3) To maintain a patient treatment record, documenting medical care rendered by the medical flight crew and the disposition of the patient at the receiving medical facility. The patient treatment record shall be maintained at the base hospital.

(4) To evaluate each patient for potential adverse effects from flight operations.

(5) To assure that the patient and equipment are secured during flight.

(b) *Minimum qualifications.* Air ambulance medical air crew members shall have the following minimum qualifications:

(1) Recognition as a Pennsylvania licensed health professional or certification as an EMT-paramedic.

(2) Knowledge and skill in the application, operation, care and removal

of on-board medical equipment used in the care of the patient, as well as knowledge of potential in-flight complications which may arise from the use of the equipment, and the treatment of these complications, as well as knowledge of flight physiology.

(3) Training in the use of extrication devices, rescue and survival techniques appropriate to the terrain and the conditions under which the service is operated.

(4) Knowledge of policies and procedures of the air ambulance service.

(5) Knowledge of safety operations in and around aircraft, and in-flight and post-flight aircraft accident and incident procedures.

(6) Knowledge of the use of the installed aircraft and portable communications equipment.]

§1003.43. [Air ambulance pilot.] (Reserved).

[(a) *Roles and responsibilities.* A pilot employed and dispatched for air ambulance service flight shall have the following responsibilities:

(1) To assure that the aircraft is ready for flight at all times.

(2) To proceed expeditiously and as directly as possible to the flight destination considering weather, appropriate safety rules, noise abatement procedures, flight path and altitude clearances.

(3) To flight follow with the communications center at intervals not to exceed 15 minutes. If the aircraft is outside the radio range of the base communications center, adequate flight following shall be planned and executed.

(b) *Minimum qualifications.* Pilots employed and dispatched for air ambulance service flight shall:

(1) Meet FAA requirements for medical certification, licensing and aircraft type ratings pertaining to the flight, as specified at 14 CFR Part 135 (relating to air taxi operators and commercial operators).

(2) Be trained in, and familiar with, the Pennsylvania Emergency Medical Services Communications Systems within their service area.

(3) Be trained by the manufacturer in the operation of the specific type of aircraft, and have at least 5 hours of flying time in the aircraft before serving as pilot in command.

(4) Be specifically trained, and preferably experienced, in flying the terrain and conditions unique to the air ambulance service area.

(5) Possess recurrent training in accordance with FAA requirements found at 14 CFR 135.351 (relating to recurrent training).

(6) Hold a current rotorcraft certification with a minimum of 2,000 rotorcraft flight hours as pilot in command.]

§1003.44. [Air ambulance communications specialist.] (Reserved).

[(a) *Roles and responsibilities.* Communications specialists who dispatch air ambulance service aircraft have the following responsibilities:

(1) To take emergency calls and dispatch appropriate air ambulance services to respond to the emergency.

(2) To document the following information:

(i) Time of initial and subsequent air ambulance request calls.

(ii) Name of party or agency requesting the air ambulance service and a verification phone number.

(iii) Pertinent patient medical information.

(iv) Names of referring and receiving physicians at hospitals.

(v) Landing and destination sites.

(vi) The details of needed ground transportation arrangements at pick-up and landing sites.

(vii) Times and reasons for aborted or missed flights.

(viii) Details of coordination with ground personnel for landing and receipt of the aircraft.

(ix) Other data pertinent to the service's specific needs for completing activity review reports.

(b) *Minimum qualifications.* Air ambulance communications specialists shall have training commensurate with the scope of responsibility given them by the particular dispatch center.]

CHAPTER 1005. LICENSING OF BLS AND ALS GROUND AMBULANCE SERVICES

Sec.

1005.1. General provisions.

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1005.3. Right to enter [and], inspect and obtain records.

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1005.11. [Medication] Drug use, control and security.

1005.12. [Grounds for suspension, revocation or refusal of an ambulance service license] Disciplinary and corrective actions.

1005.13. Removal of ambulances from operation.

1005.14. Invalid coaches.

1005.15. Discontinuation of service.

§1005.1. General provisions.

(a) This chapter applies to ground ambulance services. No person, or other entity, as an owner, agent or otherwise, may operate, conduct, maintain, advertise or otherwise engage in or profess to be engaged in providing a BLS or ALS ambulance service upon the highways or in other public places in this Commonwealth, unless that person holds a current valid license as a BLS or ALS ambulance service issued by the Department or [unless] is exempt[ed by] from these prohibitions under the act.

(b) The Department will license an [ambulance service] applicant as a BLS or ALS ambulance service, or both, when it meets the requirements of the act and this part.

(c) An ALS ambulance service may [be licensed to provide ALS under medical command and direction, in] employ [one or more] either or both of the following [modes] types of ambulances:

(1) A mobile intensive care unit vehicle, which is a [unit] vehicle that [responds and] is designed, constructed, equipped and maintained or operated to provide emergency medical care to and transport[s]ation of [seriously ill or injured] patients.

(2) An ALS squad unit vehicle, which is a vehicle that is specifically modified and equipped, and is maintained or operated for the purpose of transporting ALS prehospital personnel and equipment to the scene of an emergency.

[(3) An ALS transport service, which is a unit that transports patients between health care facilities/institutions.]

(d) In addition to the general requirements for exceptions in §1001.4 (relating to exceptions), the Department may grant exceptions to regulatory licensure standards for ALS and BLS ambulance services that are licensed in a contiguous state if:

(1) Requiring compliance with both states' licensure standards imposes an undue hardship on the individual or service.

(2) Standards in the contiguous state are comparable.

(3) The exception will not have a negative impact on the quality of care for the population of this Commonwealth.

§1005.2. Applications.

(a) An application for an original or renewal ambulance service licens[ur]e shall be submitted [by ambulance service providers] on forms prescribed by the Department. The application shall contain[, but not be limited to,] the following information as well as any additional information that may be solicited by the application form:

(1) Name and address of the applicant.

(2) Name under which the applicant is doing business.

(3) Type of organization - profit or nonprofit.

(4) [Type and l] Level of service -- ALS or BLS.

(5) The emergency [S]service area [served][-- both primary and mutual-aid] the applicant commits to serve, or, alternatively, a statement that the applicant intends to engage primarily in interfacility transports.

(6) Personnel [work status - partially paid, fully paid or volunteer] roster and staffing plan.

(7) [Design types and t] The number and types (BLS, mobile intensive care unit, ALS squad unit) of ambulance vehicles to be operated by the [service] applicant, and identifying information relating to those ambulances.

(8) Communication access and capabilities of the applicant.

(9) Primary physical building location, and other building locations out of which it will operate ambulances or a full description of how its ambulances will be placed and respond to emergency calls if they will not be operated out of other building locations.

[(9)] (10) Statement attesting to the veracity of the application, which shall be signed by [a responsible person affiliated with] the principal official of the

applicant.

(b) The [ambulance service] applicant shall [complete and] submit the application to the regional EMS council [in whose jurisdiction] exercising responsibility for the EMS region in which the [service is located] applicant will station its ambulances if licensed.

(1) The regional EMS council shall review the application for completeness[,] and accuracy [and conformance with regional EMS plans and protocols].

[(2) Complete applications shall be forwarded to the Department by the regional EMS council within 14 days of receipt.]

[(3)] (2) Incomplete applications shall be returned by the regional EMS council to the applicant within 14 days of receipt.

(c) Upon receipt of a complete application, the [Department] regional EMS council will schedule and conduct an onsite inspection of the applicant's [service] vehicles, equipment, and personnel qualifications, as well as other matters that bear upon whether the applicant satisfies the statutory and regulatory criteria for licensure. The inspection shall be performed within 45 days after receipt by the [Department] regional EMS council of the completed application.

(d) An ambulance service shall submit a change of vehicle form to the regional EMS council within ten days after placing a new ambulance in service, and may continue to operate the ambulance unless its authority to do so is disapproved by the Department following inspection.

(e) An ambulance service shall apply for and secure an amendment of its license prior to substantively altering the location or operation of its ambulances in an EMS region, such as a change in location or operations which would not enable it to timely respond to emergencies in the emergency service area it committed to serve when it applied for a license. The application for an amendment of an ambulance service license shall be submitted to the regional EMS council on a form prescribed by the Department.

§1005.3. Right to enter [and], inspect and obtain records.

(a) Upon the request of an employee or agent of the Department during regular and usual business hours, or at other times when that person possesses a reasonable belief that violations of this part may exist, a licensee shall:

(1) Produce for inspection records maintained under §1001.41 (relating to data and information requirements for ambulance services).

(2) Produce for inspection [personnel and other employment], permit copying, and provide within a reasonable period of time, records that pertain to [certification of] personnel and their qualifications, staffing, equipment [and mutual aid agreements,] supplies, and policies and procedures required pursuant to §1005.10 (relating to licensure and general operating standards).

(3) Permit the [agent] person to examine vehicles, required equipment and supplies, [recordkeeping] and security facilities [for information collected under §1001.41].

(b) The Department's [agent] representative shall advise the licensee that the inspection is being conducted under section 12(k) of the act (35 P.S. §693[8]2(k)) and this chapter.

[(c) The Department reserves the right to enter and make inspections at least quarterly, and at other times upon complaint or a reasonable belief that violations of this part may exist.]

[(d)] (c) Failure of a licensee to produce records [for inspection] or to permit an examination [of equipment and facilities] as required by this section constitutes misconduct in operating the ambulance service and shall be grounds for [suspension, revocation] disciplinary sanctions or denial of license.

§1005.4. Notification of deficiencies to applicants.

(a) [Within 30 days of an inspection,] Upon completion of the license inspection the inspector shall provide the applicant for an ambulance service license [and the regional EMS council shall be notified as to] an inspection report specifying the results of the inspection.

(b) If the [Department has] inspector determine[d]s that deficiencies warrant a reinspection, the [Department will give written notice to the applicant and the regional EMS council of the deficiencies] inspector shall give the ambulance service written notice of the matters to be reinspected.

(c) If the type of deficiency requires a plan of correction, [T]the applicant shall have 30 days in which to [respond to the Department] provide the inspector with a plan to correct the deficienc[ies]y. [The Department will review the plan of correction, and, i]If the plan is found to be acceptable, the [Department] inspector will [make an onsite] conduct a reinspection in accordance with the time frame given in the plan of correction.

(d) [Within 30 days of the reinspection, the Department will give written notice to the applicant and the regional EMS council of the results of the reinspection.] If the applicant disagrees with any deficiency cited by the inspector following the inspection or reinspection, or the regional EMS council's rejection of a plan of correction, the applicant shall apprise the Department of the matter in dispute, and the Department will resolve the dispute.

(e) [When the applicant meets the requirements of this part, the Department will proceed with the licensure process.] The Department will act upon the license application within 30 days after the inspection process has been completed.

§1005.5. Licensure.

(a) A license to operate as an ambulance service will be issued by the Department when it has [been] determined that requirements for licensure have been met.

(b) A license certificate will [indicate] specify the name of the ambulance service, its license number, the address of its primary headquarters, the dates of issuance and expiration, the levels of service the ambulance service [provider] is authorized to provide, and the name of the regional EMS council through which

the license application was processed. If the ambulance service is an ALS ambulance service, the license certificate will also specify the type or types of ALS ambulance the ambulance service has been authorized to use.

[(c) A license shall be issued for each level of service being provided by the licensee. The issuance of a license for both BLS and ALS shall be determined by the contents of the application, and with the concurrence of the regional EMS council, within whose jurisdiction the applicant is located or headquartered.]

[(d)] (c) The current license certificate shall be displayed in a public and conspicuous place in the ambulance service's primary headquarters.

[(e)] (d) An ambulance [vehicle of an ambulance service] shall be identified by a decal issued by the Department which shall be considered part of its license and which shall be applied to the outside of the [vehicle] ambulance in a conspicuous place.

[(f)] (e) An ambulance decal issued by the Department may not be displayed on a vehicle by an [service] entity not [currently] licensed as an ambulance service by the Department.

[(g)] (f) A license shall be nontransferable and shall remain valid for 3 years unless revoked or suspended by the Department.

§1005.6. Out-of-State providers.

Ambulance services located or headquartered outside of this Commonwealth that [have primary response areas or routinely] regularly engages in the business of providing emergency medical care and transportation of patients from within this Commonwealth, to facilities within or outside this Commonwealth, are required to be inspected and licensed by the Department.

§1005.7. Services owned and operated by hospitals.

[Ambulance services owned and operated by a] A hospital[,] licensed under

Chapter 8 of the Health Care Facilities Act (35 P.S. §§448.801-448.820) [are] is not required to obtain a separate ambulance service license to [provide] own and operate an ambulance service. [These] An ambulance service[s are] owned and operated by a hospital is subject to the act and this part, and shall be inspected under this part, regardless of whether the hospital secures a license to operate as an ambulance service.

§1005.7a. Renewal of ambulance service license.

(a) The Department will notify the ambulance service to renew its license at least 120 days prior to the expiration date of the license.

(b) An ambulance service shall apply for renewal of its license between 120 days and 60 days prior to the expiration of its license. Failure to apply for renewal in a timely manner may result in the applicant not securing a renewal of its license before the prior license expires.

(c) The criteria for license renewal are the same as the requirements that would apply for original licensure at the time the renewal application is made.

§1005.8. Provisional license[s].

(a) If an ambulance service or an applicant for an ambulance service license fails to meet licensure requirements, [T] the Department may issue it a provisional license, valid for a specific time period of not more than 6 months, when the Department [finds that an ambulance service:] deems it is in the public interest to do so.

(b) The Department may renew a provisional license once, for a period not to exceed six months except when a longer period of renewal is permitted under subsection (c), if:

(1) The ambulance service [H] has substantially, but not completely, complied with applicable requirements for licensure.

(2) The ambulance service [Is complying] is making a good faith effort to comply with a course of correction approved by the Department.

(3) [Has existing deficiencies that will not adversely affect the health, welfare or safety of citizens of this Commonwealth.] The Department deems it is in the public interest to do so.

[(b) A provisional license may be renewed for 6 months if the Department determines that the ambulance service is making a good faith effort to correct existing deficiencies and it is in the public interest to do so.]

(c) The Department may renew a provisional BLS ambulance service license for a period of 12 months for a volunteer [fire department or a volunteer] ambulance service, or a volunteer fire department or rescue service that operates an ambulance service, which does not meet the minimum standards for staffing at the [basic life support] BLS level of care, but meets the other requirements of this chapter.

§1005.9. Temporary licens[ur]e.

When [a new] an ALS ambulance service or an applicant for an ALS ambulance service license [or existing ALS service] cannot provide service 24 hours-a-day, 7 days-a-week, the Department may issue a temporary license for operation of the ALS ambulance service when the Department deems it is in the public interest to do so. The temporary license is valid for 1 year and may be renewed once.

§1005.10. Licensure and general operating standards.

(a) *Documentation requirements.* An applicant for an ambulance service license shall have the following documents available for the inspection by the Department:

(1) Roster of active personnel, including certification and recognition

documentation with dates of expiration and identification numbers, and its process for scheduling staff to ensure that the minimum staffing requirements set forth in subsection (d) are met.

(2) If applicable, [C]copies of prehospital ambulance [trip] call reports, or other formats on which those records are kept on patients treated or transported[, or both, during the 3-month period prior to the inspection date].

(3) If applicable, [C]call volume records from the previous year's operations. These records shall include a record of each call received requesting the ambulance service to respond to an emergency, as well as a notation of whether it responded to the call and the reason if it did not respond.

(4) [Copies of mutual-aid agreements with other ambulance services which service the applicant's community or applicant's service area.] A record of the time periods for which the ambulance service notified the PSAP that it would not be available to respond to a call.

(5) Copies of all written policies required by this section.

(b) *Ambulance [Vehicle] standards.* For [A]ambulance vehicles which transport patients [and were purchased after June 1, 1985, shall at the time of purchase or acquisition meet or exceed the Federal Specification KKK-A-1822, and amendments and revisions thereto, Section 1.2.1 *Ambulance Types, Classes and Floor Plans* and Section 3.1 *General Vehicular Design Types and Floor Plans* or other National standards as recognized and approved by the Department. Ambulance vehicles purchased before June 1, 1985,] the ambulance service will be required to show evidence that the vehicle has met [the requirements of the Federal Specification KKK-A-1822] the Vehicle Code, 75 Pa.C.S.§§4571-4572 (relating to equipment of authorized and emergency vehicles) and 67 Pa. Code Chapter 173 (relating to flashing or revolving lights on emergency and authorized vehicles), and the Federal KKK standards which were in effect at the time of vehicle's manufacture and which are not inconsistent with the Vehicle Code standards. These specifications will be for [or that the vehicle met the requirements of the Department's Voluntary A]ambulance design types,

floor plans and general configuration [Certification Program (VASC) at the time of VASC certification]. An ALS squad unit vehicle is not subject to the Federal KKK standards; however, it is required to meet the Vehicle Code standards.

(c) *Equipment and supplies.* [Approved] Required equipment and supplies shall be carried and readily available in working order for use on BLS and ALS vehicles.

(1) BLS and ALS vehicles shall carry [BLS] medical equipment and supplies as [specified by the Department.

(2) The minimum list of equipment and supplies for BLS and ALS vehicles will be] published by the Department in the *Pennsylvania Bulletin* on an annual basis, or more frequently.

[(3)] (2) An ALS squad unit vehicle is exempt from the requirement of carrying patient litters and equipment which is permanently installed.

[(4) ALS vehicles and ALS squad units shall carry ALS medical equipment, supplies and drugs as prescribed by the Department.]

[(5)] (3) A BLS ambulance service[s] may carry ALS equipment and drugs [for use by the], in addition to those generally prescribed for use by a BLS ambulance service, only if it has a physician medical director who has education and continuing education in ALS and prehospital care.[affiliated with the service as long as the physician] and who is directly responsible for security, accountability, administration and maintenance of the equipment and drugs, [and when the service is approved to operate in this manner by the regional EMS council and the Department] provided that such arrangement is authorized by the Department upon its determination that the arrangement is in the public interest.

(d) *Personnel requirements.*

(1) *Minimum staffing requirements.*

(i) *BLS unit.* [Minimum staffing standards for ambulance services that operate at the BLS level of care shall be as follows:

(A)] A BLS [A]ambulance[s], when transporting a patient, except

for when engaging in the routine transfer of convalescent or other nonemergency cases, shall be staffed by at least two persons, one of whom shall be an EMT, EMT-paramedic, or health professional, and one of whom shall, at least, qualify as an ambulance attendant[s]. [At least one attendant] An EMT, EMT-paramedic or a health professional shall accompany the patient in the patient compartment of the ambulance during transport. [Ambulance personnel between 16-18 years of age shall be directly supervised by an adult crew member with equal or greater training during patient treatment and transport.

(B) Effective July 1, 1990, ambulances, when transporting patients, except for routine transfer of convalescent or other nonemergency cases, shall be staffed by at least two persons, one of whom shall be an EMT, EMT-paramedic or health professional, and one of who shall, at least, qualify as an ambulance attendant. The patient shall be accompanied in the patient compartment by the crew member with the highest level of certification.]

(ii) *ALS units.* Minimum staffing standards for an ambulance [services] that is operat[e]ing at the ALS level of care shall be as follows:

(A) Two persons shall respond to calls for assistance. This staff shall consist of one of the following:

(I) Two health professionals.

(II) One health professional and either one EMT or one EMT-paramedic.

(III) One EMT and one EMT-paramedic.

(IV) Two EMT-paramedics.

(B) An ALS ambulance service may be staffed by one EMT-paramedic or one health professional when responding to calls for assistance, if the minimum ALS staffing requirements in this subsection are met during emergency medical treatment and transport of the patient.

(C) An ALS squad unit meets minimum staffing requirements by transporting an EMT-paramedic or health professional to rendezvous with a BLS ambulance, and having the EMT-paramedic or health professional provide

emergency medical treatment to, and accompany on the BLS ambulance during transport, a patient requiring ALS care.

(D) Minimum ALS staffing standards apply to the ALS ambulance service 24 hours-a-day, 7 days-a-week, however, an ALS mobile intensive care unit, itself, need only satisfy BLS ambulance staffing requirements under paragraph (1)(i) when responding to a call for BLS assistance exclusively. If the nature of the assistance requested is unknown, the mobile intensive care unit shall respond as if the patient requires ALS care.

(iii) *All units.* Minimum staffing standards are satisfied when an ambulance service has a duty roster that identifies staff who meet minimum staff criteria and who have committed themselves to be available at the specified times, and when minimum required staff are present during the emergency medical treatment and transport of a patient.

(2) *ALS service medical director.* An [licensed] ALS ambulance service shall have an ALS medical director whose duties include the following:

(i) Providing medical guidance and advice to the ambulance service.

(ii) Making medical command authorization determinations for EMT-paramedics and prehospital registered nurses as set forth in §1003.28 (relating to medical command authorization).

(iii) Reviewing the medical command authorization status of EMT-paramedics and prehospital registered nurses utilized by the ALS ambulance service as set forth in §1003.28 at least once annually.

(iv) Evaluating the quality of patient care provided by the ALS and BLS prehospital personnel utilized by the ALS ambulance service.

(3) *Ambulance drivers.* An ambulance service shall ensure that a person who drives an ambulance for that service is a responsible person. Notwithstanding other considerations that may bear upon whether a driver of an ambulance is a responsible person, [A] a person who drives an ambulance [vehicle] for an [licensed] ambulance service shall not be considered to be a responsible person unless that individual:

(i) [Be] Is at least 18 years of age.

(ii) [Hold] Has a valid driver's license.

(iii) Observes [relevant] all traffic laws.

(iv) Is [N]not [be] addicted to, or under the influence of, alcohol or drugs.

(v) [Be] Is free from physical or mental defect or disease that may impair the person's ability to drive an ambulance.

[(vi) Not have been convicted within the last 4 years of driving under the influence of alcohol or drugs, and, within the last 2 years, not have been convicted of reckless driving or have had a driver's license suspended under the point system. Persons who have been convicted of one or more of these violations shall repeat an emergency vehicle operator's course of instruction approved by the Department.]

[(vii)] (vi) [Take and] Has successfully completed an emergency vehicle operator's course of instruction[,] approved by the Department[, within 3 years of course approval. Personnel who have completed an emergency vehicle operator's course of instruction acceptable to the Department by July 1, 1992, shall be deemed to be in compliance with this requirement].

[(vi)] (vii) Has not been convicted within the last 4 years of driving under the influence of alcohol or drugs, or , within the last 2 years, has not been convicted of reckless driving or had a driver's license suspended. Such person shall not be considered to be a responsible person until the designated time has elapsed and the individual, after the conviction or suspension of license, repeats an emergency vehicle operator's course of instruction approved by the Department.

[(e) *Coverage agreement.*

(1) A licensed ambulance service shall have a written agreement with one or more neighboring ambulance services for coverage during times when its own ambulance is not available for service in its primary response area. The agreement shall specify the respective duties, responsibilities and coverage

times of the parties involved and shall be filed with the Department.

(2) An ambulance service which is unable to provide 24-hours-a-day, 7-day-a-week services shall provide for alternate ambulance service either through a mutual aid agreement or other type of contract as approved by the regional EMS council.

(3) When a licensed ambulance service does not have an ambulance enroute to a reported emergency call within 10 minutes of the time of dispatch, the call shall be referred to the closest available ambulance service. Once a request for service has been referred to another service, if the referring service is subsequently able to initiate a response which will access the patient more quickly than the service to which the request was referred, the service which can access the patient most quickly shall respond.]

(e) *Communicating with PSAPs.*

(1) *Responsibility to communicate unavailability.* An ambulance service shall apprise the PSAP in its area as to when it will not be in operation and when its resources are committed in such a manner that it will not be able to have an ambulance and required staff respond to a call requesting it to provide emergency assistance.

(2) *Responsibility to communicate delayed response.* An ambulance service shall apprise the PSAP, as soon as practical after receiving a dispatch call, if it is not able to have an ambulance and required staff immediately en route to an emergency.

(3) *Responsibility to communicate with PSAP generally.* In addition to the communications required by paragraphs (1) and (2), an ambulance service shall provide a PSAP with information, and otherwise communicate with a PSAP, as the PSAP requests to enhance the ability of the PSAP to make dispatch decisions.

(4) *Response to dispatch by PSAP.* An ambulance service shall respond to a call for emergency assistance as communicated by the PSAP.

[(f) *Policy and procedures.* An ambulance service shall establish written

policies and procedures governing the function of personnel, the operation of ambulances and the provision of EMS. The policies shall be available for inspection by the Department and shall address the following topics:

(1) *Recordkeeping.* An ambulance service shall have a written policy requiring responding ambulance personnel to complete a prehospital ambulance trip report on forms provided by the Department for each ambulance call to which the service responds.

(2) *Scene control.* An ambulance service shall establish a written policy on scene control directing prehospital personnel as follows:

(i) Control of all aspects of patient management at an emergency scene shall be the responsibility of the individual in attendance who has the highest level of EMS certification/recognition. For the purposes of this section, level of certification/recognition, shall be as follows:

(A) 1 -- Health professional.

(B) 2 -- EMT-paramedic.

(C) 3 -- EMT.

(D) 4 -- First responder.

(E) 5 -- Ambulance attendant.

(ii) If a prehospital care provider is not available, the authority is vested in the most appropriately trained representative of a public safety agency at the scene of the emergency.]

(f) *Patient management.* All aspects of patient management are to be handled by a prehospital practitioner with the level of EMS certification or recognition necessary to care for the patient based upon the condition of the patient.

[(3)](g) *Use of lights and other warning devices.* [Ambulance services shall establish a policy covering the use of warning devices which includes the following requirements:

(i)] Ambulances [responding to an incident scene or to an emergency care facility] may use emergency lights or audible warning devices, or both, [for cases] only when transporting or responding to a call involving a patient[s with

life-threatening or potentially life-threatening illnesses or injuries] who presents or is in good faith perceived to present a combination of circumstances resulting in a need for immediate medical intervention. When transporting the patient, the need for immediate medical intervention must be beyond the capabilities of the ambulance crew using available supplies and equipment.

[(ii) Ambulances responding to the incident scene or to an emergency care facility may not use emergency lights and audible warning devices for cases involving patients that do not have life-threatening or potentially life-threatening illnesses or injuries].

[(4)] (h) *Weapons and explosives.* [Ambulance services shall establish a written policy directing that w]Weapons and explosives may not be worn by ambulance personnel or carried aboard an ambulance. This subsection does not apply to law enforcement officers who are serving in an authorized law enforcement capacity.

(i) *Accident, injury and fatality reporting.* An ambulance service shall report to the appropriate regional EMS council, in a form or manner prescribed by the Department, an ambulance vehicle accident that is reportable under the Vehicle Code, and an accident or injury to an individual that occurs in the line of duty of the ambulance service that results in a fatality, or medical treatment at a facility. The report shall be made within 24 hours after the accident or injury. The report of a fatality shall be made within 8 hours after the fatality.

(j) *Medical command notification.* An ALS ambulance service shall identify, to the regional EMS council having responsibility in the region out of which it operates, the prehospital personnel used by it that have medical command authorization in the region for that ALS ambulance service. It shall also notify the regional EMS council when a prehospital practitioner loses medical command authorization for that ALS ambulance service.

(k) *Monitoring compliance.* An ambulance service shall monitor compliance with all requirements that the act and this part impose upon the ambulance service and its staff.

(l) *Policies and procedures.* An ambulance service shall maintain written policies and procedures addressing each of the requirements imposed by this section, as well as the requirements imposed by §§1001.41 (relating to data information requirements for ambulance services), 1001.42 (relating to dissemination of information), 1001.65 (relating to cooperation), and 1005.11 (relating to drug use, control and security), and shall also maintain written policies and procedures addressing infection control, management of personnel safety, and the placement and operation of its ambulances.

§1005.11. [Medication] Drug use, control and security.

(a) An [licensed ALS] ambulance service may stock [certain approved] drugs [and medications for emergency medical purposes, under written authorization by the medical director of a regional EMS council,] as approved by the Department, and shall carry drugs in an ambulance in conformance with the [ALS plan for the service's area] transfer and medical treatment protocols applicable in the region in which its ambulance is stationed. Additional drugs may be stocked by an ALS ambulance service as authorized by the ALS service medical director if the ALS ambulance service uses health professionals, and additional drugs may be carried or brought on an ambulance as follows:

(1) Drugs which the applicable regional transfer and medical treatment protocols prescribe for the treatment of an ALS patient may be brought on a BLS ambulance by an EMT-paramedic or health professional when rendezvousing with a BLS ambulance to treat an ALS patient on behalf of an ALS ambulance service.

(2) Drugs other than those authorized by the applicable regional transfer and medical treatment protocols may also be carried on an ALS ambulance, or brought on board a BLS ambulance by a health professional, when the requirements of subsection (d)(2) are satisfied.

(3) Drugs other than those authorized by the applicable regional transfer

and medical treatment protocols may also be carried on an ALS ambulance, or brought on board a BLS ambulance by a registered nurse, physician assistant, or physician when the following standards are met:

(i) The ambulance is engaged in an interfacility transport.

(ii) The physician, registered nurse, or physician assistant has special training required for the continuation of treatment provided to the patient at the facility, and the use of drugs not maintained on the ambulance is or may be required to continue that treatment.

(iii) The physician, registered nurse, or physician assistant does not substitute for required staff.

(4) A BLS ambulance service[s], if not also licensed as both an ALS and BLS ambulance service, may not [possess] stock drugs [or medications] which are not prescribed by the Department for use by a BLS ambulance, and a BLS ambulance service may not carry such drugs, except as authorized under this section and §1005.10(c)[(5)] (3) (relating to licensure and general operating standards).

(b) The Department will publish at least annually by notice in the *Pennsylvania Bulletin* a list of drugs [and medications] approved for use by [licensed ALS] ambulance services when also permitted by the applicable regional transfer and medical treatment protocols.

(c) [For purposes of emergency administration, a]An [licensed ALS unit] ambulance service may [have possession of certain designated controlled substances and other] procure and replace drugs, [as approved and published by the Department on an annual basis through an appropriate service contract or written affiliation with] from a hospital, pharmacy or from a participating and supervising physician, if not otherwise prohibited by law. [Responsibility for drugs and controlled substances remains with the original dispensing physician, hospital or pharmacy of record. Replacement of designated controlled substances and other drugs may be obtained from a dispensing physician, hospital or pharmacy of record if subsections (j) and (k) are followed.]

(d) Administration of drugs [and medications] by prehospital personnel, other than those approved for use by a BLS ambulance service, shall be restricted to [ALS personnel] EMT-paramedics and health professionals who have been authorized to administer [medication] such drugs by the [regional] ALS service medical director, when under orders of a medical command physician[,] or pursuant to standing orders in the EMS region[al]'s transfer and medical treatment protocols [or standing orders]; except all prehospital personnel other than a first responder and an ambulance attendant may administer to a patient, or assist the patient to administer, drugs previously prescribed for that patient, as specified in the Statewide BLS medical treatment protocols.

(1) An EMT-paramedic is restricted to administering drugs permitted by the applicable regional transfer and medical treatment protocols and the Statewide BLS medical treatment protocols.

(2) A health professional may administer drugs in addition to those permitted by the applicable regional transfer and medical treatment protocols and the Statewide BLS medical treatment protocols, provided the health professional has received approval to do so by the ALS service medical director of the ambulance service, and has been ordered to administer the drug by the medical command physician.

(e) [Areas of control including labeling, adulteration, misbranding, checking expiration dates and storage shall be adhered to by the practitioner who has responsibility for the drugs as is required under The Controlled Substance, Drug, Device and Cosmetic Act (35 P.S. §§780-101---780-144). The original dispensing practitioner to ALS units as identified on the ambulance service license application will examine drug stock to insure product quality and will reconcile the inventory of drugs a minimum of once a month for supply and administration records.] The ambulance service shall adequately monitor and direct the use, control and security of drugs provided to the ambulance service. This includes, but is not limited to:

(1) Ensuring proper labeling and preventing adulteration or misbranding

of drugs, and ensuring drugs are not used beyond their expiration dates.

(2) Storing drugs as required by the Controlled Substance, Drug, Device and Cosmetic Act (35 P.S. §§780-101--780-144), and as otherwise required to maintain the efficacy of drugs and prevent their misappropriation.

(3) Including in the ambulance call report information as to the administration of drugs by patient name, drug identification, date and time of administration, manner of administration, dosage, name of the medical command physician who gave the order to administer the drug, and name of person administering the drug.

(4) Maintaining records of drugs administered, lost or otherwise disposed of, and records of drugs received and replaced.

(5) Providing the pharmacy, physician or hospital that is requested to replace a drug, with a written record of the use and administration, or loss or other disposition of the drug, which identifies the patient and includes any other information required by law.

(6) Ensuring, in the event of an unexplained loss or theft of a controlled substance, that the dispensing pharmacy, physician or hospital has contacted local or state police and the department's Drugs, Devices and Cosmetics Office, and has filed a DEA Form 106 with the Federal drug enforcement administration.

(7) Arranging for the original dispensing pharmacy, physician or hospital, or its ALS service medical director, to provide it consultation and other assistance necessary to ensure that it meets the requirements of this section.

[(f) When drugs are administered, records shall verify the administration of the drug by patient name, drug identification, date and time of administration; dosage, name of physician who provided medical command and name of person administering the drug.

(g) When drugs are administered, an adequate record of use shall be maintained for a minimum of 2 years by the involved parties. Variations in maintaining records are acceptable; however, a process shall be in effect which provides for the written verification of medication orders. Records shall be kept

by each licensed service of drugs distributed, supplied and resupplied to them, and be made available to the Department for inspection upon demand.

(h) Drugs and medications administered by a licensed or certified EMT-paramedic or health professional shall be maintained and controlled in conformity with The Controlled Substance, Drug, Device and Cosmetic Act (35 P.S. §§780-101--780-144) and the Pharmacy Act (63 P.S. §§390-1--390-13).

(i) A physician giving a medical command to an EMT-paramedic or health professional to administer a drug shall first identify the drug and then specify the dosage and the manner of administration.

(j) When a Schedule II controlled substance has been ordered and administered, the prescribing physician shall, within 72 hours, forward a signed prescription to the dispensing/replacing pharmacy, hospital or physician. The prescription for the controlled substance shall include the information required by law and the physician's DEA number.

(k) A hospital, physician or pharmacy may replace a drug, controlled substance or legend device to a licensed ambulance service upon presentation of a written record of use and administration. This written record shall include information required by law and patient identification.

(l) No licensed ambulance service may purchase or acquire legend drugs and controlled substances except as provided for in subsection (c).

(m) In the event of an unexplained loss or theft of controlled drugs, a dispensing hospital/pharmacy or physician shall contact local or State police or the State Bureau of Drug Control. In addition, a DEA Form 106 shall be filed with the Federal Drug Enforcement Administration.]

§1005.12. [Grounds for suspension, revocation or refusal of an ambulance service license.] Disciplinary and corrective actions.

(a) The Department may, in compliance with proper administrative procedure, reprimand, or suspend, revoke or refuse to issue a license, or issue a

provisional or temporary license as permitted by §§1005.8 (relating to provisional license) and 1005.9 (relating to temporary license) for the following reasons:

(1) A serious violation of the act or this part. A serious violation is one which poses a continued significant threat to the health and safety of the public.

(2) Failure of the licensee or applicant to submit a reasonable timetable to correct deficiencies and violations cited by the Department.

(3) The existence of a continuing pattern of deficiencies over a period of 3 or more years.

(4) Fraud or deceit in obtaining or attempting to obtain a license [or permit].

(5) Lending a license or borrowing or using the license of another, or knowingly aiding or abetting the improper granting of a license.

(6) Incompetence, negligence or misconduct in operating the ambulance service or in providing EMS to patients.

(7) Failure of an ALS ambulance service to secure an ALS service medical director and to ensure that the ALS service medical director meets the roles and responsibilities in §1003.5(a) (relating to ALS service medical director).

(8) Failure to have appropriate medical equipment and supplies required for licensure as identified in §1005.10(c) (relating to licensure and general operating standards).

(9) [Failure to staff a sufficient number of certified or licensed personnel to provide service 24 hours-a-day, 7 days-a-week, or failure to provide agreements as per §1005.10(e)(2).] Failure of an ALS ambulance service to staff a sufficient number of qualified EMS personnel to provide service 24 hours-a-day, 7 days-a-week in accordance with required staffing standards.

(10) Failure of the ambulance service licensee to promptly notify the Department of a change of ownership.

(11) Abuse or abandonment of a patient.

(12) Unauthorized disclosure of medical or other confidential information.

(13) Willful preparation or filing of false reports or records, or the inducement of another to do so.

(14) Alteration or inappropriate destruction of medical records.

(15) Refusal to render EMS because of a patient's race, sex, creed, [N]national origin, sexual preference, age, handicap, medical problem or financial inability to pay.

(16) Failure to comply with the regional EMS council transfer and medical treatment protocols[, plans, policies and procedures] which have been approved by the Department.

(17) Misuse or misappropriation of drugs/medication.

(18) [A consistent pattern of a failure to respond to emergency calls within a 10 minute time period.] Repeated failure by an ambulance service to communicate with the PSAP or comply with the dispatch communication as required by §1005.10(e) (relating to licensure and general operating standards).

[(19) Other reasons as determined by the Department to pose a significant threat to the health and safety of the public.]

(b) Upon receipt of a written complaint describing [specific violations of the ambulance regulations] conduct for which the Department may take disciplinary action against an ambulance service, the Department will:

(1) Initiate an investigation of the specific charges.

(2) [Notify] Provide the ambulance service with a copy of the [charges] complaint and [investigation procedures] request a response unless the Department determines that disclosure to the ambulance service of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) [Conduct and d] Develop a written report of the investigation.

(4) Notify the [ambulance service] complainant of the results of the investigation of the complaint, as well as the ambulance service if the ambulance service has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed pursuant to paragraph (3).

(c) [The Department will immediately suspend, after a hearing has been

held, the license for the violations specified in subsection (a)(1), (6), (11), (15) and (17). This suspension shall be for a period of up to 90 days. A second offense of these enumerated violations during the same license period shall result in the automatic revocation of the license.

(1) The Department will suspend the license for other violations for a period to be determined by the Department. The Department may revoke a license for repeated violations.

(2) Upon suspension or revocation of an ambulance license, the service shall cease operations and no person may permit or cause the service to continue.

(3)] The Department will provide public notification of [suspension or revocation of] the sanction it imposes upon an ambulance service license.

§1005.13. Removal of ambulances from operation.

(a) When a vehicle manifests evidence of a mechanical or equipment deficiency which poses a significant threat to the health or safety of patients or crew, [it] the ambulance service shall [be] immediately suspend[ed] the vehicle from operation. No vehicle, which has been suspended from operation, may be operated as an ambulance until the deficiency has been corrected.

(b) When a vehicle, upon examination by the Department, manifests evidence of a mechanical or equipment deficiency which poses a significant threat to the health or safety of patients or crew, it shall be immediately suspended from operation as directed by the Department. No vehicle, which has been suspended from operation by the Department, may be operated as an ambulance until the Department has certified that the deficiency has been corrected.

§1005.14. Invalid coaches.

(a) Invalid coaches, as defined at §1001.2 (relating to definitions), are not eligible for licensing as an ambulance.

(b) The terms "ambulance," "emergency," or other similar designations may not be used by invalid coaches. Invalid coaches may not be equipped with emergency warning devices, audible or visible, such as flashing lights, sirens, air horns or other devices except those which are required by 75 Pa.C.S. §§101-9910 (relating to the Vehicle Code).

§1005.15. Discontinuation of service.

An ambulance service shall not discontinue service, except upon order of the Department, without providing each regional EMS council, PSAP and the chief executive officer of each political subdivision within its service area 90 days advance notice. The ambulance service shall also advertise notice of its intent to discontinue service in a newspaper of general circulation in its service area at least 90 days in advance of discontinuing service, and shall provide the Department with written notice that it has met these responsibilities at least 90 days in advance of discontinuing service.

CHAPTER 1007. LICENSING OF AIR AMBULANCE SERVICES-ROTORCRAFT

Sec.

1007.1 General provisions.

1007.2 Applications.

1007.3 [Licenses.] **(Reserved).**

1007.4 [Renewal of air ambulance license.] **(Reserved).**

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1007.7 Licensure and general operating requirements.

1007.8 [Grounds for suspension, revocation or refusal of an air ambulance license.] Disciplinary and corrective actions.

1007.9 [Voluntary discontinuation of service.] **(Reserved).**

§1007.1. General provisions.

(a) This chapter applies to air ambulance services. [Except as provided in subsection (c), n]No [agency or] person [either], or other entity, as owner, agent or otherwise, may furnish, operate, conduct, maintain, advertise, engage in or profess to engage in providing an air ambulance service in this Commonwealth, unless the agency or person holds a [current valid] license as an air ambulance service issued by the Department or is exempted from these prohibitions under the act.

(b) The Department will license an applicant as an air ambulance service when it meets the requirements of the act and this part.

(c) [Air ambulance services operated by] A hospital[s] licensed under Chapter 8 of the Health Care Facilities Act (35 P.S. §§448.801-448.820) [are] is not required to obtain a separate air ambulance service license to own and operate

an air ambulance service. [The] An air ambulance service owned and operated by a hospital is subject to the act and this part, and shall be inspected under this part, regardless of whether the hospital applies for or secures licensure as an air ambulance service.

(d) The Department will issue a [permit] certificate acknowledging a hospital's authority to own and operate an air ambulance service[s operated by hospitals] if the hospital chooses to operate an air ambulance service without securing a separate license to do so.

(e) The provisions in sections 1005.3 (relating to right to enter, inspect and obtain records), 1005.4 (relating to notification of deficiencies to applicants), 1005.5 (relating to licensure), 1005.7a (relating to renewal of ambulance service license), 1005.8 (relating to provisional license), 1005.9 (relating to temporary license), 1005.11 (relating to drug use, control and security), 1005.13 (relating to removal of ambulances from operation) and 1005.15 (relating to discontinuation of service), which are applicable to ground ALS ambulance services, are also applicable to air ambulance services.

§1007.2. Applications.

[(a) An application for a license to operate an air ambulance service may be obtained from the Pennsylvania Department of Health, Division of Emergency Medical Services, Post Office Box 90, Harrisburg, Pennsylvania 17108.]

[(b)] (a) An application for an original or renewal license to operate as an air ambulance service shall [be submitted to the Department and shall] contain the following information, as well as any additional information that may be solicited by the application form:

(1) The name and address of the [vendor of the air ambulance service or proposed ambulance service] applicant and the name [and address], if different, under which the [service will be operating] applicant intends to operate.

(2) The [name, address and] FAA certification number of the aircraft

operator.

(3) [The experience and qualifications of the applicant to operate an air ambulance service.] The type of organization - profit or nonprofit.

(4) A description of each aircraft to be used as an air ambulance, including the make, model, year of manufacture, FAA registration number, name, monogram or other distinguishing designation and FAA air worthiness certification.

(5) The [geographical] intended emergency medical service area and the location and description of the places from which the air ambulance service is to operate.

(6) The name, training and qualifications of the air ambulance medical director[, who has responsibility for auditing the medical care provided by the air ambulance service].

(7) A personnel roster [of medical personnel] which includes level of certification, [or] licensure and recognition, and a staffing plan.

(8) A roster of pilots including training and qualifications.

(9) [A statement in which the applicant agrees to provide patient specific data, as identified by the Department, to the Department.] The communications access and capabilities of the applicant.

(10) [Other information the Department deems necessary and prescribes as part of the application.] A statement attesting to the veracity of the application, which shall be signed by the chief executive officer.

(b) The applicant shall submit the application to the regional EMS council exercising responsibility for the EMS region in which the applicant will station its air ambulances if licensed.

(1) The regional EMS council shall review the application for completeness and accuracy.

(2) Incomplete applications shall be returned by the regional EMS council to the applicant within 14 days of receipt.

(c) Upon receipt of a complete application, the regional EMS council will

schedule and conduct an onsite inspection of the applicant's air ambulances, equipment, and personnel qualifications, as well as other matters that bear upon whether the applicant satisfies the statutory and regulatory criteria for licensure. The inspection shall be performed within 45 days after receipt by the regional EMS council of the completed application.

(d) An air ambulance service shall apply for an amendment of its license and secure Department approval of the amendment prior to commencing the operation of an air ambulance not previously inspected and approved by the Department or substantively altering its plan for locating and operating air ambulances, except that if the air ambulance service is replacing an air ambulance, at the same location, it may operate the air ambulance immediately, apply for an amendment within 10 days, and continue to operate the air ambulance unless its authority to do so is disapproved by the Department following inspection.

§1007.3. [Licenses.] (Reserved).

[(a) Within 30 days of receipt of an appropriately completed application from the air ambulance service applicant, the Department will initiate the licensure process.

(b) The Department will issue a regular license to operate an air ambulance service after an onsite inspection and review conducted by the Department indicates that the applicant's service is in compliance with the act, this part, other applicable laws and the regional EMS plan for the areas to be served.

(c) An air ambulance license will be issued for 3 years from the date of issue and will remain valid for that period of time unless revoked or suspended by the Department. Annual inspections shall be conducted to assure compliance.

(d) Change of ownership requires reapplication for a license. An air ambulance service licensee shall file with the Department an application for renewal of the ambulance service license within 10 business days of acquisition

of the service by the new owner.

(e) Change of aircraft operator requires submission of supplemental information to the Department within 10 business days of the effective date of the operator change. The licensee shall provide the Department with new information required under §1007.2(b)(2), (4) and (7) (relating to applications). The Department may inspect the aircraft operator and each aircraft to assure compliance with appropriate provisions of this part before the license is renewed.

(f) Upon change of aircraft during the licensing period, another application for an air ambulance license shall be submitted to the Department on the form prescribed. If the change of aircraft is for a temporary period, not to exceed 30 days, the air ambulance service shall only notify the Department of the change and the reasons.

(g) The current license shall be posted in a conspicuous place in the air ambulance service's operations center and on or in the aircraft where it is clearly visible.]

§1007.4. [Renewal of air ambulance license.] (Reserved).

[(a) The Department will notify the applicant service at least 90 days prior to the expiration date of the license. The notification will include a renewal application.

(b) The applicant shall submit to the Department the renewal application postmarked at least 60 days prior to the expiration of the license.

(c) The criteria for license renewal are the same as the current requirements for original licensure.]

§1007.5. [Inspections.] (Reserved).

[(a) Upon the request of an agent of the Department during regular and usual business hours, or at other times when a reasonable belief that violations of this

part may exist, a licensee shall:

(1) Produce for inspection records maintained under §1001.41(c) (relating to data and information requirements for ambulance services).

(2) Produce for inspection personnel and other employment records that pertain to certification of personnel, staffing, equipment and mutual aid agreements.

(3) Permit the [agent] to examine required equipment and recordkeeping facilities for information collected under §1001.41(c).

(b) The Department's agent shall advise the licensee that the inspection is being conducted under section 12(k) of the act (35 P.S. §6932(k)) and this chapter.

(c) The Department reserves the right to enter and make the inspections at least quarterly, and at other times upon complaint or a reasonable belief that violations of this part may exist.

(d) Failure of a licensee to produce records for inspection or to permit examination of equipment and facilities is grounds for suspension, revocation or denial of license.]

§1007.6. [Notification of deficiencies.] (Reserved).

[(a) Within 30 days of an inspection, the air ambulance service and the regional EMS council shall be notified as to deficiencies found and the results of the inspection.

(b) The ambulance service has 30 days in which to respond to the Department with a plan to correct deficiencies and schedule a reinspection. The plan of correction shall be approved by the Department. If the plan is approved, the Department will schedule a reinspection.

(c) Within 30 days of the reinspection, the Department will give written notice to the service of the findings regarding the deficiencies and the results of the reinspection.]

§1007.7. Licensure and general operating requirements.

(a) *Documentation requirements.* An applicant for an air ambulance service license shall have the following documents available for the inspection by the Department:

(1) Roster of active personnel, including certification and recognition documentation with dates of expiration and identification numbers, and the plan for staffing the air ambulance service.

(2) If applicable, copies of prehospital ambulance call reports, or other formats on which those records are kept on patients treated or transported.

(3) If applicable, call volume records from the previous year's operations. These records shall include a record of each call received requesting the air ambulance service to respond to an emergency, as well as a notation of whether it responded to the call and the reason if it did not respond.

(4) Copies of all written policies required by this section.

[(a)] (b) *Air[craft] ambulance requirements.* An [Aircraft operated by a licensed] air ambulance [service] shall meet the following minimum requirements:

(1) The air[craft] ambulance shall be configured to carry at least one supine patient with sufficient access to the patient in order to begin and maintain ALS and other treatment modalities.

(2) The air[craft] ambulance design may not compromise patient safety in loading, unloading or during flight, and shall be equipped with either a cargo door or an entry that will allow loading and unloading the patient without excessive maneuvering.

(3) The air[craft] ambulance shall be climate controlled for the comfort of the patient.

(4) The air[craft] ambulance shall have adequate interior lighting so that medical care can be provided and patient status monitored without interfering with the pilot's vision.

(5) The air[craft] ambulance shall be configured so that the patient is isolated

from the cockpit to minimize in-flight distractions to the pilot and to prevent interference with the pilot's manipulation of the flight controls.

(6) An air ambulance operating from sunset to sunrise shall be equipped with at least one tail rotor illuminating light and a controllable search light.

(7) The air[craft] ambulance shall carry survival gear appropriate to the terrain and environment [shall be carried on flights].

(8) The air[craft] ambulance shall be equipped with appropriate patient restraints.

(9) The air[craft] ambulance shall be equipped with 110 [A] V electrical output with appropriate cabin outlets for medical equipment use.

(10) The air[craft] ambulance shall be equipped with two-way radios capable of communicating with hospital communications centers, [public safety communication centers] PSAPs and ambulances.

[(b)] (c) *Equipment and supply requirements.* [Approved] Required equipment and supplies shall be carried and readily available in working order for use on [aircraft operated by a licensed] an air ambulance [service]. The [minimum] list of required equipment and supplies for an air[craft] ambulance will be published by the Department [as a notice] in the *Pennsylvania Bulletin* on an annual basis.

[(c) *Medications.* Approved medications and drugs shall be carried and available for administration to patients on aircraft operated by a licensed air ambulance service. The minimum list of medications and drugs for aircraft will be published by the Department as a notice in the *Pennsylvania Bulletin* on an annual basis.

(d) *Patient data.* Air ambulance services licensed to operate in this Commonwealth shall collect, maintain and report accurate and reliable patient data and information for calls for assistance in the format prescribed or on forms provided by the Department within the specified time period.

(1) The information collected shall include information identified in §1001.41 (relating to data and information requirements for ambulance services).

(2) Air ambulance services licensed to operate in this Commonwealth shall

meet the requirements of §1001.41 and §1001.42 (relating to dissemination of information).]

[(e)] (d) *Personnel requirements.* An [A]air ambulance service[s] shall meet the following requirements related to personnel and staffing:

(1) *Air ambulance medical director.* [The service] It shall [employ] have an air ambulance medical director who possesses the qualifications specified in [§1003.41(b) (relating to air ambulance medical director)] §1003.5(b) (relating to ALS service medical director) [to serve as the medical director responsible for] and performs the duties specified in [§1003.41] §1003.5(a). [If the air ambulance medical director leaves or is removed from service, a qualified replacement shall be hired within 30 days of the previous medical director's departure. The air ambulance service shall inform the Department of a change in air ambulance service medical directors within 30 days of a medical director's departure].

(2) *Pilot and prehospital personnel.* [The service] It shall assure that each air ambulance responding to a call for EMS services is staffed with at least one pilot and [two medical crew members who possess the minimum qualifications defined in §§1003.42(b) and 1003.43(b) (relating to air ambulance medical crew members; and air ambulance pilot)] prehospital personnel as set forth in §1005.10(d)(1)(ii) (relating to licensure and general operating standards). At least one of the [medical crew members] responding prehospital personnel shall be [either a physician or nurse] specially trained in [aero] air-medical transport.

(3) *Other personnel requirements.*

(i) [The service] It shall keep a pilot and two [medical crew members] prehospital personnel staff as set forth in §1005.10(d)(ii) available for the air[craft] ambulance at all times to assure immediate response to emergency calls.

[(4) The service shall have a communications center operational 24 hours per day, 7 days per week and staffed with a communications specialist who has the minimum qualifications in §1003.44(b) (relating to air ambulance communications specialist).]

[(5)] (ii) [The service] It shall require [that flight crew members] prehospital personnel who staff an air ambulance to undergo annual physical examinations to assure that they are physically able to perform their jobs.

(iii) Minimum staffing standards are satisfied when an air ambulance service has a duty roster that identifies staff who meet minimum staff criteria 24 hours-a-day, 7 days-a-week and who have committed themselves to be available at the specified times, and when minimum required staff are present during the emergency medical treatment and transport of a patient.

(e) *Communicating with ground PSAPs.*

(1) If requested by a ground PSAP, an air ambulance service shall apprise the PSAP as to when it will not be in operation, when weather conditions prevent or impede flight, and when its resources are already committed.

(2) An air ambulance service shall apprise the dispatching ground PSAP as soon as practical after receiving a dispatch call, its estimated time of arrival at the scene of the emergency. While its air ambulance is enroute to the scene of an emergency, if an air ambulance service believes that it will not be able to have an air ambulance and required staff arrive at the emergency scene within the estimated time of arrival previously given, the air ambulance service shall contact the ground PSAP and provide its new estimated time of arrival.

(f) *[Policy requirements.* The air ambulance service shall have in place written policies as follows:]

[(1)] *Access to air ambulance service.*

[(i)] (1) The air ambulance service shall have [in place a written policy which describes its policy regarding access to its service. This policy shall include the following information] a policy which addresses the following:

[(A)] (i) Who, in addition to a PSAP, may request air ambulance service.

[(B)] (ii) How its air ambulance services should be accessed.

[(C)] (iii) General and medical guidelines for personnel to consider prior to requesting its air ambulance services.

[(D)] (iv) To whom the air ambulance service provides its services,

including general service area.

[(E)] (v) What level of EMS [are] is provided by the air ambulance service.

[(F)] (vi) Patient preparation guidelines.

[(G)] (vii) Aircraft enplanement and safety requirements.

[(ii)] (2) The air ambulance service shall disseminate [T]this policy [shall be disseminated] to relevant health care providers in the air ambulance['s] service's service area.

[(2)] (g) *[Air ambulance pilot operational] Flight requirements.* Th[is]e air ambulance service shall [have in place a written policy governing pilot operational procedures which includes the following requirements] ensure that:

[(i)] (1) [The pilot shall make a] A determination to accept the flight is based solely on safety procedures and weather conditions.

[(ii)] (2) The [pilot shall] air ambulance proceeds expeditiously and as directly as possible to the flight destination, considering the weather, appropriate safety rules, noise abatement procedures and flight path and altitude clearances.

[(iii)] (3) The [pilot shall] air ambulance engages in flight following with an air communications center at intervals not to exceed 15 minutes. If the air[craft] ambulance is outside of radio range of the base communications center, adequate flight following shall be planned and executed.

[(iv)] (4) The [pilot is responsible for assuring that the] air[craft] ambulance is ready for flight at all times when the air ambulance service has not reported to ground PSAPs that the air ambulance is unavailable to respond to emergencies.

[(3)] (h) *Medical [crew members' operational] service requirements.* The air ambulance service shall [have in place a written policy governing medical crew members operational procedures which includes the following requirements] ensure that:

[(i)] (1) [Medical crew members are responsible for assuring that e]Equipment[/] and supplies required for an air ambulance flight are on the air[craft] ambulance and in working order prior to takeoff for patient transport.

[(ii)] (2) [Medical crew members shall provide m]Medical care and intervention is provided according to direct medical command or written protocols/standing orders.

[(iii)] (3) [Medical crew members shall maintain a] A patient treatment record is maintained, documenting medical care rendered by the medical flight crew and the disposition of the patient at the receiving medical facility. The patient treatment record shall be maintained at the base hospital.

[(iv)] (4) [Medical crew members shall evaluate e]Each patient is evaluated for potential adverse effects from flight operations.

[(v)] (5) [Medical crew members shall assure that t]The patient and equipment are secured during flight.

[(4)] (i) *Air ambulance medical director's operational requirements.* The air ambulance service shall have [in place] a [written] policy setting forth the air ambulance medical director's operational procedures which shall include procedures for at least the following:

[(i)] (1) [To assure that the medical condition or history of the patient is made known only to medical crew members, and other EMS providers who have participated in the delivery of patient care.] The performance of responsibilities set forth in §1003.5(a) (relating to ALS service medical director).

[(ii) To assure adequate training and experience of medical flight crew members.]

[(iii)] (2) The develop[ing]ment of medical treatment protocols for [use by medical crew members] the air ambulance service, [and] submitting them [for approval] to the regional EMS council medical [direction] advisory committee for its review and recommendations, and securing approval of the medical treatment protocols from the Department.

[(iv) For establishing and operating a quality assurance program whereby the quality and appropriateness of patient care provided by the air ambulance service can be continuously documented, reviewed and evaluated.]

[(5)] (j) *Communication center [operational requirements] arrangements.*

The air ambulance service shall [have in place a written policy governing communication center operational procedures which includes the requirements that the communications center shall] ensure that it has access to an air communications center that meets the following standards:

[(i)] (1) [Have] Has a designated person--communications specialist--assigned to receive and dispatch requests for emergency air medical services and charged with the relay of information between the flight crew, requesting agency and receiving hospital.

[(ii)] (2) [Be] Is operational 24 hours [per]-a-day, 7 days-a-week and [have] has radio capabilities to transmit to and receive from the air ambulance [aircraft]. At a minimum, 123.05 MHz, radio frequency shall be available.

[(iii)] (3) [Have] Has at least one incoming telephone line that is dedicated to the air ambulance service.

[(iv)] (4) [Have] Has a system for recording incoming and outgoing telephone and radio transmissions. The system shall have an inherent time recording capability and recordings shall be kept for a minimum of 30 days.

[(v)] (5) [Have] Has the capability of communicating with the flight crew so that the air[craft] ambulance may take off within the scheduled takeoff time.

[(vi)] (6) [Have] Has a backup emergency power source.

[(vii)] (7) Maintains a status board listing flight crew names and other pertinent operational information.

[(viii)] (8) [Have] Has copies of operational protocols and procedures, including emergency operation plans in the event of overdue, missing or downed aircraft.

[(ix)] (9) [Have] Has posted or displayed applicable licenses and permits.

[(x)] (10) Maintains current maps and navigational aids.

[(6) *Communications specialist operational requirements.* The service shall have in place a written policy governing communication specialist operational procedures. The written policy shall include a requirement that the communication specialist document contains, at a minimum, the following

information:]

(11) Collects and maintains records of the following data:

(i) The time of initial and subsequent air ambulance request calls.

(ii) The name of the party or agency requesting the air ambulance service and a verification phone number.

(iii) Pertinent patient medical information.

(iv) The names of referring and receiving physicians at hospitals.

(v) The landing and destination sites.

(vi) The details of needed ground transportation arrangements at pickup and landing sites.

(vii) The times and reasons for aborted or missed flights.

(viii) The details of coordination with ground personnel for landing and receipt of the aircraft.

(ix) Other data pertinent to the air ambulance service's specific needs for completing activity review reports.

[(g)] (k) *Community education program requirements.*

(1) An air ambulance service shall develop a professional and community education program that will promote proper aeromedical service utilization.

(2) The educational program shall include the following:

(i) [The service shall c]Communicat[e]ion to the public that the [emergency] air [medical] ambulance service accepts medically necessary calls from authorized personnel and does not discriminate against a person because of race, creed, sex, color, age, religion, [N]national origin, ancestry, medical problem, handicap or ability to pay.

(ii) A safety program covering landing site designation and safe conduct around the air[craft] ambulance, which shall be offered to appropriate agencies and individuals.

(iii) Training regarding stabilization and preparation of the patient for airborne transport, which shall be provided to prehospital [EMS] personnel.

(iv) [The service shall institute a]An active community relations program.

(l) *Medical command notification.* An air ambulance service shall identify, to the regional EMS council having responsibility in the region out of which it operates, the prehospital personnel used by it that have medical command authorization in the region for that air ambulance service. It shall also notify the regional EMS council when a prehospital practitioner loses medical command authorization for that air ambulance service.

(m) *Monitoring compliance.* An air ambulance service shall monitor compliance with all requirements that the act and this part impose upon the air ambulance service and its staff.

(n) *Policies and procedures.* An air ambulance service shall maintain written policies and procedures addressing each of the requirements imposed by this section, as well as the requirements imposed by §§1001.41 (relating to data and information requirements for ambulance services), 1001.42 (relating to dissemination of information), and 1001.65 (relating to cooperation), and shall also maintain written policies and procedures addressing infection control, management of personnel safety, and the placement and operation of its air ambulances.

§1007.8. [Grounds for suspension, revocation or refusal of an air ambulance license.] Disciplinary and corrective actions.

(a) The Department may, in compliance with proper administrative procedure, reprimand, or suspend, revoke or refuse to issue a license, or issue a provisional or temporary license as permitted by §§1005.8 (relating to provisional license) and 1005.9 (relating to temporary license) for the following reasons:

(1) A serious violation of the act or this part. A serious violation is one which poses a continued significant threat to the health and safety of the public.

(2) Failure of the licensee or applicant to submit a reasonable timetable to correct deficiencies and violations cited by the Department.

(3) The existence of a continuing pattern of deficiencies over a period of 3

three or more years.

(4) Fraud or deceit in obtaining or attempting to obtain a license [or permit].

(5) Lending a license or borrowing or using the license of another, or knowingly aiding or abetting the improper granting of a license.

(6) Incompetence, negligence or misconduct in operating the ambulance service or in providing EMS to patients.

(7) Failure to secure an air ambulance medical director and ensure that the air ambulance medical director [meets the roles and] exercises the responsibilities in [§1003.41(a) (relating to air ambulance medical director)] §1003.5(a) (relating to ALS service medical director).

(8) Failure to have appropriate medical equipment and supplies required for licensure as identified in §1007.7(b) (relating to licensure and general operating requirements).

(9) Failure of the air ambulance service to have an aircraft equipped in compliance with §1007.7(a).

(10) Failure of the aircraft operator to maintain required FAA certifications.

(11) Failure to employ a sufficient number of certified, recognized or licensed personnel to provide service 24 hours[per]-a-day, 7 days-a-week.

(12) Failure of the air [medical] ambulance service to be available 24 hours [per]-a-day, 7 days-a-week to authorized callers within the service area. Exceptions to this requirement include unsafe weather conditions, commitment to another flight, grounding due to maintenance or other reasons that would prevent response. The air [medical] ambulance service shall maintain a record of each failure to respond to a request for service, and make the record available upon request to the Department. Financial inability to pay does not constitute sufficient grounds to deny response for emergency air service.

(13) Failure [of an air ambulance service licensee] to notify the Department of the change of ownership or aircraft operation.

(14) Abuse or abandonment of a patient.

(15) Unauthorized disclosure of medical or other confidential information.

(16) Willful preparation or filing of false medical reports or records, or the inducement of another to do so.

(17) Destruction of medical records.

(18) Refusal to render EMS because of a patient's race, sex, creed, [N]national origin, sexual preference, age, handicap, medical problem or financial inability to pay.

(19) Failure to comply with regional EMS council transfer and medical treatment protocols.

(20) Misuse or misappropriation of drugs/medication.

(21) [Other reasons as determined by the Department which pose a significant threat to the health and safety of the public.] Repeated failure to communicate with a PSAP as required by §1007.7(e) (relating to licensure and general operating requirements).

(b) Upon receipt of a written complaint describing [specific violations of this chapter] conduct for which the Department may take disciplinary action against an air ambulance service, the Department will:

(1) Initiate an investigation of the specific charges.

(2) [Notify] Provide the air ambulance service with a copy of the [charges] complaint and [investigation procedures] request a response unless the Department determines that disclosure to the air ambulance service of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) [Conduct and d]Develop a written report of the investigation.

(4) Notify the [air ambulance service] complainant of the results of the investigation of the complaint, as well as the air ambulance service if the air ambulance service has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed pursuant to paragraph (3).

[(c) The Department will immediately suspend the license for the violations specified in §1005.12 (a)(1), (6), (11), (15) and (17) (relating to grounds for

suspension, revocation or refusal of an ambulance service license). This suspension shall be for a period of up to 90 days. A second offense during the same license period shall result in the automatic revocation of the license.

(d) The Department will suspend the license for other violations for a period to be determined by the Department. The Department may revoke a license for repeated violations.

(e) Upon suspension or revocation of an air ambulance license, the service shall cease operations and no person may permit or cause the service to continue.]

[(f)] (c) The Department will provide public notification of [suspension, including the length of suspension period or revocation of] sanctions it imposes upon an air ambulance service license.

[(g) Upon suspension or revocation of an air ambulance license, the service shall cease operations and no person may permit or cause the service to continue.]

§1007.9. [Voluntary discontinuation of service.] (Reserved).

[(a) Air ambulance service licenses may not voluntarily discontinue service until 90 days after the licensee notifies the Department in writing that the service is to be discontinued.

(b) Notice to the Department shall include a statement that the licensee has notified the chief executive officer of each political subdivision in the licensee's ambulance service area and that the intent to discontinue service has been advertised in a newspaper of general circulation in the service area.

(c) The air ambulance service licensee shall notify the Department in advance of anticipated temporary discontinuance of service expected to last for at least 7 consecutive days.]

CHAPTER 1009. [EMS] MEDICAL COMMAND [MEDICAL] FACILITIES

Sec.

1009.1. [Accreditation and o] Operational criteria.

1009.2. [Accreditation] Recognition process.

1009.3. [Continuity of medical command.] **(Reserved).**

1009.4. [Suspension/revocation of accreditation.] Withdrawal of medical command facility recognition.

1009.5. [Biennial r]Review of [accredited] medical command facilities.

1009.6. Discontinuation of service.

§1009.1. [Accreditation and o] Operational criteria.

Medical command facilit[ies]y standards [shall be accredited by the Department]. To qualify [for accreditation] as a[n EMS] medical command facility, an institution shall [demonstrate that it] compl[ies]y with the following criteria [related to personnel, capabilities, procedures and programs by]:

(1) Employ[ing] a [physician] medical command facility medical director who meets the requirements specified at §1003.3(b) (relating to medical command facility medical director) [for a medical command facility medical director].

(2) Employ[ing] sufficient staff to ensure that at least one approved medical command physician, meeting the requirements specified of §1003.4(b) (relating to medical command physician), is present in the facility 24 hours [per]-a-day, 7 days[per]-a-week.

(3) [Possessing communication capabilities and recordkeeping protocols that

provide for the following:] Satisfy the following communication and recordkeeping requirements:

(i) Compatibility with regional telecommunication systems plans, if in place.

(ii) Communications by way of telecommunications equipment/radios with BLS and ALS units within the [respective medical service] area in which medical command is exercised.

(iii) Tape recording of medical command communications.

(iv) Maintenance of a medical command record, containing [specific] appropriate information on patients for whom medical command is sought.

(v) An appropriate program for training emergency department staff in the effective use of telecommunication equipment.

(vi) Protocols to provide for prompt response to requests from prehospital personnel for radio or telephone medical guidance, assistance or advice.

(4) [Demonstrating the capacity to a]Accurately and promptly relay information regarding patients to the appropriate receiving [hospital] facility.

(5) Adher[ing]e to [transportation instruction and hospital assignment] transfer and medical treatment protocols established by the regional EMS council, or, when dealing with an air ambulance service, as approved by the Department.

(6) Establish[ing] a program of regular case audit conferences involving the medical command facility medical director or [his] the director's designee and prehospital personnel for purposes of problem identification, and a process to correct identified problems.

(7) Obtain[ing] a contingency agreement with at least one other medical command facility to assure availability of medical command.

(8) Establish[ing] internal procedures that comply with regional EMS transfer and medical treatment protocols [developed by the respective regional EMS council].

(9) Notify PSAPs, through which it routinely receives requests for medical command, when it will not have a medical command physician available to

provide medical command.

(10) Establish a plan to ensure that medical command is available at all times during mass casualty situations, natural disasters, and declared states of emergency.

[(9)] (11) Participat[ing]e in the [respective] regional EMS council's quality [assurance] improvement program[s] for monitoring the delivery of EMS.

[(10)] (12) Adopt[ing] procedures for maintaining medical command communication records and tapes under §117.43 (relating to medical records).

[(11)] (13) Employ[ing] sufficient administrative support staff to enable the institution to carry out its essential duties which include, but are not limited to: audits, [continuing education], equipment maintenance, and processing and responding to complaints.

[(12)] (14) Establish[ing] a program of training [and continuing education] for medical command physicians, prehospital personnel and emergency department staff.

(15) Provide medical command to prehospital personnel whenever they seek direction.

§1009.2. [Accreditation] Recognition process.

(a) [Regional EMS councils shall recommend to the Department those facilities which meet the criteria for accreditation. If the applying facility disagrees with the recommendation of the regional EMS council, it may submit a written request for reconsideration by the council.] To qualify for the civil immunity protection afforded by section 11(j)(4) of the act (35 P.S. §6931(j)(4)), a facility shall secure recognition as a medical command facility from the Department. To secure recognition as a medical command facility, a facility shall submit an application to the Department through a regional EMS council exercising responsibility for an EMS region in which the applicant intends to provide medical command through medical command physicians who function

under its auspices. Application for medical command facility recognition shall be made on forms prescribed by the Department.

(b) [The Department has 60 days to accredit or deny accreditation from the time of receipt of the regional EMS council's recommendation.] The regional EMS council will review the application for completeness.

(c) [Denial of accreditation shall be based on cause.] If the application is complete, the regional EMS council shall conduct an on-site inspection of the applying facility to verify information contained within the application and to complete a physical inspection of the medical command area.

(d) [The Department may review and inspect facilities to aid in accreditation decisions.] After completing its review, the regional EMS council shall forward a copy of its recommendation to the Department and to the applying facility. If the applying facility disagrees with the recommendation of the regional EMS council, it may submit a written rebuttal to the Department.

(e) [If the applying facility disagrees with the decision by the Department, an appeal may be filed under 2 Pa.C.S. §§501-508 and 701-704 (relating to Administrative Agency Law).] The Department will review the application, information and recommendation submitted by the regional EMS council, and the rebuttal statement, if any, submitted by the applying facility, and will make a decision within 60 days from the time of its receipt of the regional EMS council's recommendation to grant or deny recognition.

(f) The Department may review and inspect facilities to aid it in making medical command facility recognition decisions.

(g) If the applying facility disagrees with the decision by the Department, it may appeal the decision pursuant to 1 Pa. Code §35.20 (relating to appeals from actions of the staff) if the decision was not issued by the agency head as defined in 1 Pa. Code §31.3 (relating to definitions) and, if it disagrees with the decision of the agency head, it may file an appeal under 2 Pa. C. S. §501-508 and 701-704 (relating to Administrative Agency Law).

(h) Recognition as a medical command facility shall be valid for three years.

A facility shall file an application for renewal of its recognition as a medical command facility 60 days prior to expiration of the medical command facility's recognition from the Department. Failure to apply for renewal of recognition in a timely manner may result in the facility having a lapse in the civil immunity protection afforded by 35 P.S. §6931(j)(4).

§1009.3. [Continuity of medical command.] (Reserved).

[A facility recognized by the regional EMS council as a medical command facility as of July 1, 1989 shall continue to be accredited until July 1, 1991, or until surveyed by the Department, whichever comes first.]

§1009.4. [Suspension/revocation of accreditation.] Withdrawal of medical command facility recognition.

(a) The Department may [suspend accreditation for up to 90 days for the following reasons:

(1) Failure to comply with regional EMS council protocols or guidelines.

(2) Violation of accreditation criteria in §1009.1 (relating to [accreditation and] operational criteria).

(3) Failure to cooperate in the data collection and retrieval procedures required by the Department.

(4) Other reasons deemed appropriate by the Department.

(b) A medical command facility shall correct the deficiencies that were cited by the Department as reasons for suspension by the end of the suspension period set by the Department.

(c) The Department may revoke accreditation for failure to correct deficiencies within the suspension period.] withdraw medical command facility recognition if the facility fails to continue to meet the standards for a medical command facility in §1009.1.

(b) The Department shall conduct inspections of a medical command facility from time to time, as deemed appropriate and necessary, including when necessary to investigate a complaint or a reasonable belief that violations of this part may exist.

(c) If the facility fails to continue to meet the standards for a medical command facility in §1009.1, as an alternative to rescinding medical command facility recognition, the Department may request the facility to submit a plan of correction to correct the deficiencies. The procedures are as follows:

(1) The Department will give written notice to the facility and the regional EMS council of the deficiencies.

(2) The facility shall have 30 days in which to respond to the Department with a plan to correct the deficiencies.

(3) The Department will review the plan of correction and, if the plan is found to be acceptable, the Department may make an onsite reinspection in accordance with the time frame given in the plan of correction.

(4) Within 30 days after the review of the plan of correction, as well as 30 days after the reinspection, the Department will give written notice to the facility and the regional EMS council of the results of the Department's review of the plan of correction and reinspection.

(d) Upon receipt of a written complaint describing conduct for which the Department may withdraw medical command facility recognition, the Department shall:

(1) Initiate an investigation of the specific charges.

(2) Provide the medical command facility with a copy of the complaint and request a response unless the Department determines that disclosure to the medical command facility of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) Develop a written report of the investigation.

(4) Notify the complainant of the results of the investigation of the complaint, as well as the medical command facility if the medical command facility has been

officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed pursuant to paragraph (3).

§1009.5. [Biennial r]Review of [accredited] medical command facilities.

The regional EMS councils shall conduct a [biennial] review of medical command facilities as requested by the Department, and at other times may inspect, [accredited] medical command facilities. These reviews and inspections shall be conducted to audit for continued compliance with [the], at a minimum, such criteria in §1009.1 (relating to [accreditation and] operational criteria) as directed by the Department.

§1009.6. Discontinuation of service.

A medical command facility shall not discontinue medical command operations without providing 60 days advance written notice to the Department, regional EMS councils responsible for regions in which the medical command facility routinely provides medical command, and providers of EMS for which it routinely provides medical command.

CHAPTER 1011. ACCREDITATION OF TRAINING INSTITUTES

Sec.

1011.1. BLS and ALS training institutes.
1011.2. [ALS training institutes.] **(Reserved).**
1011.3. Accreditation process.
1011.4. [Suspension/revocation] Denial, restriction, or withdrawal of accreditation.

§1011.1. BLS and ALS training institutes.

(a) *Eligible entity.* A BLS and an ALS training institute shall be accredited by the Department. A [BLS] training institute shall be a secondary or postsecondary institution, hospital, regional EMS council or another entity which meets the criteria in this part.

(b) *[Accreditation criteria.* To qualify for accreditation as a BLS training institute, an entity shall demonstrate compliance with the following:

(1) *Criteria.] Training programs.*

(1) [The] A BLS training institute shall evidence the ability to conduct one or more of the following training programs approved by the Department:

(i) Emergency Medical Technician[-Ambulance] Course[, National Standard Curriculum].

[(ii) Emergency Medical Technician Refresher Course, National Standard Curriculum.]

[(iii)] (ii) [Emergency Medical Services (]EMS[)] First Responder Course[, First Edition or amendments and revisions thereto].

[(iv) EMS First Responder Refresher Course.

(v) EMT Instructor Training Program, National Standard Curriculum].

(2) An ALS training institute shall evidence the ability to conduct one or more of the following training programs approved by the Department:

(i) Emergency Medical Technician-Paramedic Course.

(ii) Prehospital Registered Nurse Course.

[(2)] (c) *Personnel.*

[(i)] (1) *Medical director.*

[(A)] (i) A[n] training institute shall have a medical director who is a physician [licensed in this Commonwealth]. The medical director shall be experienced in emergency medical care, and shall have demonstrated ability in education[/] and administration.

[(B)] (ii) The responsibilities of the medical director shall include:

[(I)] (A) [Assuring that the] Reviewing course content [is in] to ensure compliance with this part.

[(II)] (B) [Assisting with] Reviewing and approving the training institute's criteria for the recruitment, selection and orientation of training institute faculty.

[(III)] (C) Providing technical advice and assistance to training institute faculty and students.

(D) Reviewing the quality and medical content of the education, and compliance with protocols.

(E) Participating in the review of new technology for training and education.

(iii) Additional responsibilities for a medical director of an ALS training institute shall include:

(A) Approving the content of course written and practical skills examinations.

(B) Identifying and approving facilities where students are to fulfill clinical and field internship requirements.

(C) Identifying and approving individuals to serve as field and clinical preceptors to supervise and evaluate student performance when fulfilling clinical and field internship requirements.

(D) Signing skill verification forms for students who demonstrate the knowledge and skills required for successful completion of the training course and entry level competency for the prehospital practitioner for which the training course is offered.

[(ii)] (d) *Administrative director.*

[(A)] (1) A BLS training institute shall have an administrative director who [is a currently certified EMT and] has at least one year experience in administration and one year experience in prehospital care.

(2) An ALS training institute shall have an administrative director who has at least one year experience in administration and one year experience

in ALS prehospital care.

[(B)] (3) Responsibilities of the administrative director shall include ensuring:

[(I)] (i) The adequacy of the [Application] the system for processing student applications and [oversight] of the student selection process.

[(II)] (ii) [Class scheduling and assignment] The adequacy of the process for the screening and selection of instructors for the training institute.

[(III)] (iii) [Preparation, maintenance and] The institute maintains an adequate inventory of necessary training equipment and that the training equipment is properly prepared and maintained.

[(IV)] (iv) The adequate [A]administration of the course and written and practical skills examinations involved in the course.

[(V)] (v) There is an adequate system for the [M]maintenance of student records and files.

[(VI)] (vi) [Student/faculty liaison.] There is an appropriate mechanism to resolve disputes between students and faculty.

[(iii)] (e) *Course coordinator.*

[(A)] (1) The [BLS] training institute shall designate a course coordinator for each training course [of instruction] conducted by the training institute. [The coordinator shall possess certification as an EMT instructor, and shall have other qualifications as prescribed by the Department's Prehospital Personnel Training Manual.]

(2) A course coordinator shall have:

(i) Reading and language skills commensurate with the resource materials to be utilized in the course.

(ii) Knowledge of the Statewide BLS medical treatment protocols.

(3) A course coordinator for an ALS training course shall also satisfy the following requirements:

(i) One year experience in ALS prehospital care.

(ii) One year experience as an EMT-paramedic or a health professional, or as a supervisor of ALS prehospital care.

(iii) Have knowledge of the ALS transfer and medical treatment protocols for the region.

[(B)] (4) [The] A course coordinator is responsible for the management and supervision of each [BLS] training course offered by the training institute for which he or she serves as a course coordinator.

[(C)] (5) Specific duties of [the] a course coordinator [also include:

(I) Scheduling and supervising course instructors.

(II) Scheduling and supervising student clinical observation activities.

(III) Completing course records, including individual student performance summaries and scores.

(iv) Providing counseling services to students] shall be assigned by the training institute.

(6) One person may serve both as the administrative director and a course coordinator.

[(iv)] (f) *Instructors.*

[(A)] (1) A [BLS] training institute shall ensure the availability of qualified and responsible instructors for each training course. [Instructors shall meet the qualifications required by §1003.23(e) (relating to EMT).]

(2) An instructor shall be 18 years of age or older, and possess a high school diploma or GED equivalent.

(3) At least 75% of the instruction provided in training courses shall be provided by instructors who are health professional physicians or prehospital personnel and who have at least one year of experience as a health professional physician or a prehospital practitioner above the level of a first responder and at or above the level they are teaching, and have completed an EMS instructor course approved by the Department or possess a bachelor's degree in education or a teacher's certification in education; or be determined by a review body of the

training institute to meet or exceed these standards.

(4) An instructor who does not satisfy the requirements in paragraph (3) shall be qualified to provide the instructional services offered as determined by the training institute after consulting the Prehospital Practitioner Manual and with the appropriate regional EMS council.

[(B)] (5) Instructors are responsible for presenting course materials in accordance with the curriculum established by this part.

[(v) *Other faculty.* A BLS training institute may use the instructional services of other personnel as may be deemed appropriate, subject to approval by the regional EMS council.]

(g) *Clinical preceptors.*

(1) An ALS training institute shall ensure the availability of clinical preceptors for each training course.

(2) A clinical preceptor is responsible for the supervision and evaluation of students while fulfilling clinical requirements for a training program.

(h) *Field preceptors.*

(1) An ALS training institute shall ensure the availability of field preceptors for each student.

(2) A field preceptor is responsible for the supervision and evaluation of students while fulfilling a field internship for a training program.

[(3)] (i) *Facilities and equipment.* A training institute shall:

[(i)] (1) [The institute shall m]Maintain facilities necessary for the provision of [BLS] training courses. The facilities shall include classrooms and space for equipment storage, and shall be of sufficient size to conduct didactic and practical skill performance sessions. [The regional EMS council is responsible for determining the appropriateness of the facilities provided.]

[(ii)] (2) [The institute shall p] Provide and maintain the essential equipment and supplies to administer the course. These shall be [as] identified in the [Department's] Prehospital Personnel [Training] Manual.

[(4)] (j) *Operating procedures.* A training institute shall:

[(i)] (1) [The institute shall a]Adopt and implement [the Department's] a nondiscrimination policy with respect to student selection and faculty recruitment.

[(ii)] (2) [A file shall be m]Maintain[ed] a file on each enrolled student [to] which includes class performance, practical and written examination results, and reports made concerning the progress of the student during the training program.

[(iii)] (3) [The institute shall p]Provide a mechanism by which students may grieve decisions made by the institute regarding dismissal or other disciplinary action. [The grievance procedure shall be subject to approval by the regional EMS council.]

[(iv)] (4) [Students shall be p]Provide[d] students with a clear description of the program and its content, including learning goals, course objectives and competencies to be attained.

[(v) The institute shall evidence compliance with policies contained in the Department's Prehospital Personnel Training Manual.]

(5) Have a policy regarding the transfer of a student into or out of a training program from one training institute to another.

(6) Have a continuing quality improvement process in place for students, instructors, and clinical evaluation.

§1011.2. [ALS training institutes.] (Reserved).

[(a) *Eligible entity.* An ALS training institute shall be accredited by the Department. An ALS training institute shall be a secondary or a postsecondary institution, hospital, EMS council or another entity which meets the criteria in this part.

(b) *Criteria.* To qualify for accreditation as an ALS training institute, an entity shall demonstrate compliance with the following:

(1) *Training programs.* The institute shall evidence the ability to conduct one or more of the following training programs approved by the Department.

(i) Emergency Medical Technician-Paramedic Course, National

Standard Curriculum.

(ii) Emergency Medical Technician-Paramedic Refresher Course, National Standard Curriculum.

(iii) Health professional.

(2) *Administration.*

(i) *Medical director.*

(A) An institute shall have a medical director who is a physician licensed in this Commonwealth. The medical director shall be experienced in emergency medical care, and shall have demonstrated ability in education/ administration.

(B) The responsibilities of the medical director include:

(I) Assuring that the course content is in compliance with this part.

(II) Assisting with the recruitment, selection and orientation of training institute faculty.

(III) Providing technical advice and assistance to training institute faculty and students.

(IV) Approving the content of written and practical skills examinations.

(V) Identifying and approving facilities and ALS services where students can fulfill clinical and field internship requirements.

(VI) Identifying and approving individuals who will serve as field and clinical preceptors for supervising and evaluating student performance when fulfilling clinical and field internship requirements.

(ii) *Administrative director.*

(A) The administrative director shall have at least 1 year of experience in administration and 1 year of experience in ALS prehospital care education.

(B) Responsibilities of the administrative director include:

(I) Application processing and oversight of the student

selection process.

(II) Class scheduling and assignment of instructors.

(III) Preparation, maintenance and inventory of necessary training equipment.

(IV) Administration of written and practical skill examinations.

(V) Maintenance of student records and files.

(VI) Student/faculty liaison.

(iii) *Course coordinator.*

(A) The ALS training institute shall designate a course coordinator for each course of instruction conducted by the training institute. The coordinator shall be a currently certified EMT-paramedic or health professional as defined in this part, and shall have other qualifications prescribed by the Department's Prehospital Personnel Training Manual.

(B) The course coordinator is responsible for the management and supervision of each ALS training course offered by the training institute.

(C) Specific duties of the course coordinator also include:

(I) Scheduling and supervising course instructors.

(II) Scheduling and supervising student clinical observation activities and field internships.

(III) Completing course records, including individual student performance summaries and scores.

(IV) Providing counseling services for students.

(iv) *Instructors.*

(A) The ALS training institute shall ensure the availability of instructors for each course.

(B) An instructor shall be experienced in the education of individuals at the ALS level, and approved by the course medical director as qualified to teach those sections of the course to which the instructor is assigned.

(C) An instructor is responsible for presenting course materials in

accordance with the curriculum established by this part.

(v) *Clinical preceptors.*

(A) The ALS training institute shall ensure the availability of clinical preceptors for each course.

(B) The clinical preceptor is responsible for the supervision and evaluation of paramedic students while fulfilling clinical requirements in an approved facility.

(vi) *Field preceptors.*

(A) The ALS training institute shall ensure the availability of field preceptors for each student.

(B) The field preceptor is responsible for supervision and evaluation of paramedic students while fulfilling field internships with an approved ALS service.

(vii) *Other faculty.* An ALS training institute may use the instructional services of other personnel as may be deemed appropriate, subject to approval by the regional EMS council.

(3) *Facilities and equipment.*

(i) The institute shall maintain facilities appropriate to conduct ALS training courses. Facilities include classrooms and space for equipment storage, and shall be of sufficient size to conduct didactic and practical skill performance sessions. The regional EMS council is responsible for determining the appropriateness of the facilities.

(ii) The institute shall provide and maintain the essential equipment and supplies as identified in the Department's Prehospital Personnel Training Manual. The equipment includes items necessary to perform skills required by the course curriculum, as defined in this part.

(4) Operating procedures.

(i) The institute shall adopt and implement the Department's nondiscrimination policy with respect to student selection and faculty recruitment.

(ii) A file shall be maintained on each enrolled student to include class

performance, practical and written examination results and reports made concerning the progress of the student during the training program.

(iii) The institute shall provide a mechanism by which students may grieve decisions made by the institute regarding dismissal or other disciplinary action. The grievance procedure shall be subject to approval by the regional EMS council.

(iv) Students shall be provided with a clear description of the program and its content, including learning goals, course objectives and competencies to be attained.

(v) The institute shall evidence compliance with policies contained in the Department's Prehospital Personnel Training Manual.]

§1011.3. Accreditation process.

For an ALS or BLS institute to be accredited by the Department, the following are required:

(1) The applicant shall submit to the regional EMS council an application for accreditation on forms developed by the Department. An applicant for reaccreditation shall submit the application at least 180 days, but not more than 1 year, prior to expiration of the current accreditation.

(2) The regional EMS council shall review the application for completeness[,] <u>and</u> accuracy [and conformance with the regional EMS plans and protocols].

(3) The regional EMS council shall have 45 days in which to review the application and to conduct an onsite assessment of the institute.

(4) The regional EMS council shall forward to the Department the application for accreditation either with an endorsement or with an explanation as to why the application has not been endorsed.

(5) Within 150 days of receipt, the Department will review the application and make one of the following determinations:

(i) *Full accreditation.* The training institute [currently] meets <u>the</u> criteria

in §[§]1011.1 [or 1011.2] (relating to BLS and ALS training institutes[; and ALS training institutes)] as applicable, and will be accredited to operate for 3 years.

(ii) *Conditional accreditation.* The training institute does not [currently] meet criteria in §[§]1011.1 [or 1011.2] as applicable, but the deficiencies identified are deemed correctable by the Department. The program will be allowed to proceed or continue with close observation by the Department. Deficiencies which prevent full accreditation shall be enumerated and corrected within a time period specified by the Department. Conditional accreditation may not exceed 1 year, and may not be renewed.

(iii) *Nonaccreditation.* The institute does not [currently] meet criteria in §[§]1011.1 [or 1011.2] and the deficiencies identified are deemed to be serious enough to preclude any type of accreditation. [The applicant may request a hearing from the Department under 2 Pa.C.S. §§501-508 and 701-704 (relating to Administrative Agency Law).]

(6) Institutes that have received full or conditional accreditation shall submit status reports to the Department as requested.

(7) Prior to and during accreditation, training institutes are subject to review, including inspection of records, facilities and equipment by the Department. An authorized representative of the Department [or its designee has the right to] may enter, visit and inspect an accredited training institute or a facility operated by or in connection with the training institute, with or without prior notification.

[(8) A training institute accredited by the American Medical Association shall be considered to have met the requirements in this part, and shall be accredited by the Department for a period to coincide with that of the American Medical Association's certification.] The Department may accept the survey results of another accrediting body if the Department determines that the accreditation standards of the other accrediting body are equal to or exceed the standards in this chapter, and that the survey process employed by the other accrediting body is adequate to gather the information necessary for the Department to make an accreditation decision.

[(9)] (8) An accredited training institute shall advise the Department at least 90 days prior to an intended change of ownership, or control of the institute. Accreditation is not transferable to new owners or controlling parties.

§1011.4. [Suspension/revocation] Denial, restriction, or withdrawal of accreditation.

(a) The Department may [suspend or revoke] deny, withdraw or condition the accreditation of a training institute [upon written complaint and investigation] for one or more of the following:

(1) Failure to maintain compliance with the applicable criteria in §[§]1011.1 [or 1011.2] (relating to BLS and ALS training institutes[; or ALS training institutes]) [and standards and policies in the Department's Prehospital Personnel Training Manual].

(2) An absence of students in the program for 2 consecutive years.

(b) Before denying or withdrawing accreditation, or granting conditional accreditation, the Department will give written notice to the institute's administrative director and the regional EMS council that the action is contemplated. The notice will identify reasons for [withdrawal of accreditation] the intended decision and will provide sufficient time for response [and a request for appeal and review of the Department's determination].

(c) [A revocation or suspension of accreditation may be appealed under 2 Pa.C.S. §§501-508 and 701-704 (relating to administrative agency law).] If an institute that applies for accreditation, or has its accreditation withdrawn or conditioned, disagrees with the decision of the Department, it may appeal the decision pursuant to 1 Pa. Code §35.20 (relating to appeals from actions of the staff) if the decision was not issued by the agency head as defined in 1 Pa. Code §31.3 (relating to definitions) and, if it disagrees with the decision of the agency head, it may file an appeal under 2 Pa. C. S. §501-508 and 701-704 (relating to Administrative Agency Law).

(d) Upon receipt of a written complaint describing conduct for which the Department may withdraw training facility accreditation, the Department shall:

(1) Initiate an investigation of the specific charges.

(2) Provide the training facility with a copy of the complaint and request a response unless the Department determines that disclosure to the training facility of the complaint will compromise the investigation or would be inappropriate for some other reason.

(3) Develop a written report of the investigation.

(4) Notify the complainant of the results of the investigation of the complaint, as well as the training facility if the training facility has been officially apprised of the complaint or investigation. This notification does not include providing a copy of the written report developed pursuant to paragraph (3).

CHAPTER 1013. SPECIAL EVENT EMS

Sec.

1013.1. Special event EMS planning requirements.

1013.2. Administration, management and medical direction requirements.

1013.3. Special event EMS personnel and capability requirements.

1013.4. ALS services requirements.

1013.5. Onsite facility requirements.

1013.6. Communications system requirements.

1013.7 Requirements for educating event attendees regarding access to EMS.

1013.8 Special event report.

§1013.1. Special event EMS planning requirements.

(a) *Procedure for obtaining required plan approval.* A person, agency or organization responsible for the management and administration of special events, as defined in §1001.2 (relating to definitions), [shall] may submit a plan for EMS to the Department, through the regional EMS council assigned responsibility for the region in which the special event is to occur, to secure a determination from the Department as to whether the plan is adequate to address the EMS needs presented by a special event or a series of special events conducted at the same location. The plan shall be [approved] submitted prior to the start of the special event or events.

(1) Persons, agencies or organizations, managing facilities or locations which are involved in special events as defined in §1001.2, who seek the Department's approval of an EMS plan for a special event or series of special events conducted at the same location, shall submit an annual plan to the [Department] appropriate regional EMS council at least [60] 90 days prior to the date of the

first scheduled event of each calendar year.

(2) The Department will approve or disapprove a special event EMS plan within [30] 60 days [of its receipt] after a complete plan is filed with the regional EMS council.

(b) *Plan content.* The special event EMS plan shall contain information, including, but not limited to:

(1) The type and nature of event, location, length and anticipated attendance.

(2) Identification of sponsoring organization.

(3) The name and qualifications of the special event supervisory physician and the special event EMS director.

(4) Identification of the number and qualifications of emergency medical personnel who will be involved.

(5) The type and quantity of emergency medical vehicles, equipment and supplies to be utilized.

(6) A description of the onsite treatment facilities including maps of the special event site.

(7) The level of care to be provided BLS, ALS or both.

(8) Patient transfer protocols and agreements.

(9) A description of the special event emergency medical communications capabilities.

(10) Plans for educating event attendees regarding EMS system access, specific hazards or severe weather.

(11) Measures that have and will be taken to coordinate EMS for the special event or events with local emergency care services and public safety agencies - such as ambulance, police, fire, rescue, and hospital agencies or organizations.

(c) *Plan approval.* To secure Department approval of an EMS plan for a special event, the applicant shall satisfy the requirements of this chapter.

§1013.2. Administration, management and medical direction requirements.

(a) *Special event EMS director.* [Emergency medical services] EMS provided at a special event shall be supervised by an individual identified as the special event EMS director.

(1) *Responsibilities.* The responsibilities of the special event EMS director include, but are not limited to:

(i) The preparation of a plan under §1013.1 (relating to special event EMS planning requirement).

(ii) Management of the delivery of special event EMS.

(iii) [Coordination of special event EMS, with local emergency care services and public safety entities - such as ambulance, police, fire rescue and hospital agencies or organizations.] Ensuring implementation of the EMS coordination measures contained in the special event EMS plan.

(2) *Qualifications.* A special event EMS director shall be experienced in the administration and management of prehospital EMS at the BLS or ALS level, depending on the level of EMS provided at the special event.

(b) *Special event emergency supervisory physician.*

(1) *Requirement.* A special event EMS system shall be directed and supervised by a [licensed] medical command physician for events involving more than [30,000] 25,000 actual or anticipated participants or attendees, or both.

(2) *Qualifications.* A special event emergency supervisory physician shall possess the following qualifications:

(i) Experience in the medical direction and supervision of prehospital EMS at the BLS or ALS level, depending on the level of care provided at the special event.

(ii) [A valid license to practice medicine in this Commonwealth as a Doctor of Medicine or Doctor of Osteopathy.] Be licensed as a physician.

§1013.3. Special event EMS personnel and capability requirements.

(a) Special event emergency medical staff shall be certified at appropriate emergency care levels based on the level of EMS provided at the special event; that is, BLS, ALS, or both.

(b) One staffed and Pennsylvania licensed ambulance vehicle shall be stationed onsite of a special event with a known or estimated population of between [10,000] 5,000 and [30,000] 25,000 participants or attendees, or both.

(c) Two staffed and Pennsylvania licensed ambulance vehicles shall be stationed onsite of a special event with a known or estimated population greater than [30,000] 25,000 but less than [60,000] 55,000 participants or attendees, or both.

(d) Three staffed and Pennsylvania licensed ambulance vehicles shall be stationed onsite of any special event with a known or estimated population greater than [60,000] 55,000 participants or attendees, or both.

(e) Sufficient personnel shall be available to assure the availability of BLS care to special event spectators or participants within 10 minutes of notification of need for emergency care. EMS personnel shall be currently certified at the ambulance attendant, first responder, EMT, EMT-paramedic or health professional level.

§1013.4. ALS services requirements.

(a) ALS services, if available, shall be provided in accordance with regional ALS plans and protocols.

(b) Where regional ALS plans and protocols are deemed inappropriate for the special event, alternate plans may be submitted for consideration by the regional EMS council under §1013.1 (relating to special event EMS planning requirements).

(c) When ALS services are provided, a sufficient number of ALS personnel shall be available to assure ALS care to patients within 10 minutes of notification of need for emergency care. The requirement for ALS personnel only applies to

special event EMS operations planned at the ALS level.

§1013.5. Onsite facility requirements.

A special event for which greater than [30,000] 25,000 participants or spectators, or both, will be involved shall require the use of onsite treatment facilities. The onsite treatment facilities shall provide:

(1) Environmental control, providing protection from weather elements to insure patient safety and comfort.

(2) Sufficient beds, cots and [BLS] equipment to provide for evaluation and treatment of at least four simultaneous patients.

(3) Adequate lighting and ventilation to allow for patient evaluation and treatment.

§1013.6. Communications system requirements.

(a) A special event EMS system shall have onsite communications capabilities to insure:

(1) Uniform access to care for patients in need of EMS.

(2) Onsite coordination of the activities of EMS personnel.

(3) Communication with existing community [emergency communications centers] PSAPs.

(4) Communication interface with other involved public safety agencies.

(5) Communication with receiving facilities.

(6) Communication with ambulances providing emergency transportation.

§1013.7. Requirements for educating event attendees regarding access to EMS.

(a) The sponsoring agency, individual or organization shall develop and implement a plan to educate special event participants and spectators about the following:

(1) The presence and location of EMS at the special event.

(2) The methods of obtaining emergency medical care at the special event.

(b) A procedure and means for alerting the participants or spectators of specific hazards or serious changing conditions, such as severe weather, shall be established and operational.

§1013.8. Special event report.

The person or organization that filed the special event EMS plan shall complete a special event report form prepared by the Department and provided to it by the relevant regional EMS council, and shall file the completed report with that regional EMS council within 30 days following a special event.

CHAPTER 1015. QUICK RESPONSE SERVICE RECOGNITION PROGRAM

Sec.
1015.1. Quick response service.
1015.2. Discontinuation of service.

§1015.1. Quick response service.

(a) *Criteria.* An applicant for recognition as a QRS shall file an application in which it shall commit to the following to receive Department recognition as a QRS:

(1) That it will maintain all essential equipment and supplies for a QRS, as published by the Department at least annually in the *Pennsylvania Bulletin*, for immediate use when dispatched.

(2) That it has capabilities to be dispatched and to communicate with a responding ambulance service.

(3) That all EMS it provides will be performed by prehospital personnel or other persons authorized by law to perform such services.

(4) That it shall satisfy the requirements applicable to ambulance services in §§1001.41 (relating to data and information requirements for ambulance services) and 1001.42 (relating to dissemination of information), for data elements included in an ambulance call report which the Department designates for completion by a QRS.

(5) That it shall provide EMS in compliance with regional medical treatment protocols and the Statewide BLS medical treatment protocols.

(b) *Recognition process.*

(1) An applicant for Department recognition as a QRS shall submit an application on forms prescribed by the Department to the regional EMS council having jurisdiction over the area in which the applicant intends to locate. The application shall contain the following information:

(i) Name and address of the applicant.

(ii) Physical location of the applicant.

(iii) Service affiliation(s) (police department, fire department, ambulance service, or other).

(iv) Service area.

(v) Types and number of vehicles it will employ, if any.

(vi) Communication access and capabilities of the applicant.

(vii) A roster of persons who have committed to serve as QRS members, and their qualifications.

(viii) A summary of how the QRS will interface with ambulance service(s).

(ix) Verification that the applicant will satisfy the requirements of subsection (a).

(x) A statement attesting to the veracity of the application, which shall be signed by the principal official of the applicant.

(2) The regional EMS council shall review the application for completeness and accuracy. It shall return an incomplete application to the applicant within 14 days of receipt.

(3) Upon receipt of a complete application, the regional EMS council shall conduct, within 45 days, an onsite inspection of the applicant to determine whether the applicant satisfies the regulatory criteria for QRS recognition. Any deficiencies identified during the inspection shall be documented and made known to the applicant. A reinspection shall be scheduled when the applicant notifies the regional EMS council that the deficiencies have been corrected. The results shall be forwarded to the Department.

(c) *Recognition.*

(1) A certificate of recognition as a QRS will be issued by the Department when it has been determined that requirements for recognition have been met.

(2) The certificate of recognition will specify the name of the QRS, the date of issuance, the date of expiration, the regional EMS council through which the

application was processed and the recognition number assigned by the Department.

(3) The QRS may identify a vehicle being utilized for response by applying to the outside of the vehicle a QRS decal issued by the Department

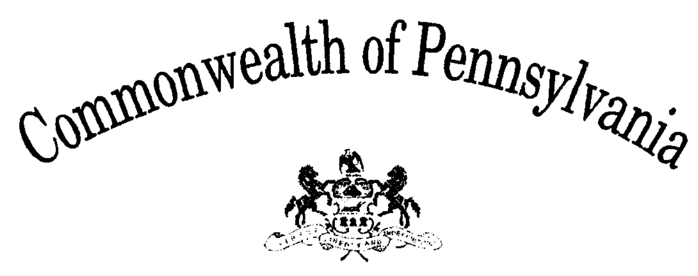
(4) The QRS decal issued by the Department may not be displayed on a vehicle not utilized for response by the QRS.

(5) A certificate of recognition shall be nontransferable and shall remain valid for 3 years unless withdrawn by the Department due to the QRS failing to continue to meet the standards for recognition as a QRS in subsection (a).

(d) *Renewal of recognition.* A QRS may continue to participate in the Quick Response Service Recognition Program by resubmitting an application in a format prescribed by the Department to the appropriate regional EMS council at least 60 days prior to the expiration date of its certificate of recognition.

§1015.2. Discontinuation of service.

A QRS shall not discontinue service, except upon order of the Department, without providing each regional EMS council and the chief executive officer of each political subdivision within its service area 90 days advance notice. The QRS shall also advertise notice of its intent to discontinue service in a newspaper of general circulation in its service area at least 90 days in advance of discontinuing service, and shall provide the Department with written notice that it has met these responsibilities at least 90 days in advance of discontinuing service.



DEPARTMENT OF HEALTH

HARRISBURG

THE SECRETARY

January 29, 1999

Robert E. Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown II
333 Market Street
Harrisburg, PA 17101

Re: Department of Health Regulations Relating to Emergency Medical Services
No. 10-143

Dear Mr. Nyce:

Enclosed is a copy of proposed regulations for review by the Commission pursuant to the Regulatory Review Act (Act) (P.L. 73, No. 19) (71 P.S. §§745.1-745.15). The proposed regulations would amend the Department's regulations promulgated under the Emergency Medical Services Act (EMS Act) (P.L. 164, No. 45) (35 P.S. §§6921-6938).

Comprehensive amendments are proposed. All seven current chapters of the emergency medical services regulations would be amended. Additionally, a new chapter, Chapter 1015 (relating to quick response services), would be added.

Section 5(g) of the Act , 71 P.S. §745.5(g), provides that the Commission, within 10 days after expiration of the Standing Committee review period, shall notify the proposing agency of any objection to the proposed regulations. The Department expects the proposed regulations to be published February 13, 1999. A 30-day comment period is provided.

Pursuant to section 5.1(a) of the Act, 71 P.S. §745.5a(a), upon completion of the Department's review of comments, the Department shall submit to the Commission a copy of the Department's response to the comments received, the text of the final-form regulations which the Department intends to adopt, and a list of the names and addresses of the commentators who requested a copy of the final-form regulations.

The Department will provide the Commission within 5 days of receipt, a copy of any comment received pertaining to the proposed regulations. The Department will also provide the Commission with any assistance it requires to facilitate a through review of the proposed

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regulations. If you have any questions, please contact Kim Sokoloski, Director of the Office of Legislative Affairs, at (717) 783-3985.

Sincerely,

Daniel F. Hoffmann

Enclosures

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

RECEIVED
99 JAN 29 PM 3:35
INDEPENDENT REGULATORY
REVIEW COMMISSION

I.D. NUMBER: 10-143

SUBJECT: Emergency Medical Services

AGENCY: DEPARTMENT OF HEALTH

TYPE OF REGULATION

X Proposed Regulation

Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
1-29-99	[signature]	HOUSE COMMITTEE ON HEALTH & HUMAN SERVICES
1-29-99	Maryanne Pelletier	
1/29/99	Kristi Knelson / Angele Sano	SENATE COMMITTEE ON PUBLIC HEALTH & WELFARE
1/29/99	Kim C Turner	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL
1-29-99	Cynthia [signature]	LEGISLATIVE REFERENCE BUREAU

October 29, 1998