State of Wisconsin
Department of Health Services

Tony Evers, Governor
Kirsten L. Johnson, Secretary

November 23, 2026

Mr. Cyrus Anderson
Acting Senate Chief Clerk
PO Box 7882
Madison, WI 53702

Mr. Edward Blazel
Assembly Chief Clerk
17 W. Main St., Room 401
Madison, WI 53703

Dear Mr. Anderson and Mr. Blazel:

I am pleased to submit to the Legislature the Wisconsin Emergency Medical Services Plan as required by Wis. Stat. § 256.08. The plan was prepared by the Division of Public Health, Emergency Medical Services Section and includes accomplishments for 2024-25 as well as initiatives for 2026-27.

Sincerely,

Kirsten L. Johnson
Secretary-designee

WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Public Health

P-00576 (11/2026)

Emergency Medical Services Plan

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Section 1—Introduction

EMS in Wisconsin

The Wisconsin emergency medical services (EMS) system serves a critical role in Wisconsin's health care, public safety, trauma, and preparedness systems in providing emergency medical care and ambulance transportation to the sick and injured. EMS fills this role by providing emergency response to medical 911 calls across the state, 24 hours a day. The EMS system provides a safe, reliable means of transporting sick and injured patients between health care facilities, both to adjust for capacity within the hospital system and to move critically ill or injured patients to specialized care not otherwise available at their local hospital. Through community EMS programs, the EMS system also helps to address gaps in primary care and other community health care needs in non-emergency settings.

Since the modern EMS system's creation just over 50 years ago, the Wisconsin EMS system has grown into a network of over 800 different service providers using thousands of trained and dedicated career, paid-on-call, and volunteer personnel across both the public and private sectors. It provides care and transportation to hundreds of thousands of patients each year with injuries and illnesses ranging from minor to life-threatening. While created to address emergencies, the EMS system at times becomes an invaluable safety net for those Wisconsinites without other access to urgent health care. Always at the ready, the EMS system continually evolves to meet any needs and challenges ahead.

Purpose

Wis. Stat. § 256.08(1) requires the Department of Health Service (DHS) to maintain a state EMS plan. This plan describes the framework of the EMS system, provides information on the current EMS system, assesses progress since the last state plan, and sets new goals for the following two years.

Scope

Wisconsin is a home rule state, meaning county and local governments have considerable autonomy in structuring and controlling their local affairs. While state statutes and regulations create the overall framework of the EMS system, provision of EMS occurs through a mixture of local government and private businesses. Decisions on how to provide EMS for 911 emergency response within the existing statutory framework, including the level and type of the EMS system, are the responsibility of county or local government. This plan therefore focuses on providing information on the EMS system and state responsibilities, leaving local decisions to policy makers at that level.

Section 2—State EMS resources

Department of Health Services

Wis. Stat. § 256.08(4)(a) designates the DHS to "[s]erve as the lead state agency for emergency medical service." DHS's duties regarding EMS are listed in Wis. Stat. § 256.08(4). The Office of Preparedness and Emergency Health Care (OPEHC) with the Division of Public Health (DPH) contains most DHS regulatory and support resources for EMS.

While each of OPEHC's four sections help support some EMS functions, most EMS functions are in the EMS Section and the Data and Systems Section. OPEHC's principal EMS functions include:

- **Certification and licensing**—The EMS Section certifies or licenses ambulance service providers, other service providers, emergency medical responders and EMS practitioners under Wis. Stat. §§ 256.15(5), (6), (7), and (8).
- **Compliance**—The EMS Section investigates complaints regarding ambulance service providers, emergency medical responders (EMR), EMS practitioners, training centers, and medical directors under Wis. Stat. § 256.08(4)(h).
- **Training**—The EMS Section sets standards for all organizations that offer training to EMRs and EMS practitioners on what topics should be included in initial training and continuing training under Wis. Stat. § 256.08(4)(e). The EMS Section also certifies training centers and instructors under Wis. Stat. § 256.15(9) and Wis. Admin. Code § DHS 110.18, 110.27, and 110.28.
- **Aid to locals**—The EMS Section, with support from OPEHC's Grants and Administration Section, annually conducts two aids to local programs. The Funding Assistance Program (FAP) annually distributes funds for training, support, and improvement to local service providers under Wis. Stat. § 256.12(4) and (5). The Telecommunicator Cardiopulmonary Resuscitation (T-CPR) Program distributes funds to public safety answering points (PSAPs) for dispatcher training on providing cardiopulmonary resuscitation (CPR) under Wis. Stat. § 256.35(2m)(d).
- **Data management**—The Data and Systems Section, with support from the EMS Section, collects and analyzes EMS data under Wis. Stat. § 256.08(4)(c).
- **EMS for Children (EMS-C)**—OPEHC administers the EMS-C Program which seeks to improve the quality of emergency medical care provided to children in Wisconsin by increasing awareness of pediatric care considerations and ensuring the availability of appropriate pediatric resources and training in both the pre-hospital and emergency department setting.
- **Public health preparedness**—OPEHC's Health Emergency Preparedness Section and Data and Systems Section help integrate EMS into the larger health care system, trauma system, and state preparedness system as required by Wis. Stat. §§ 256.08(4)(f) and (i).

OPEHC maintains two web-based systems to assist with fulfilling these functions. The EMS Section uses an electronic licensing management system (E-Licensing) to conduct most of its certification and licensing processes. Individuals and service providers have access to applications, forms, and their certification and licensing records through a public portal. The Data and Systems Section oversees the

Wisconsin Ambulance Ran Data System (WARDS) to which ambulance service providers and other non-transporting service providers submit patient care data. WARDS complies with National Emergency Medical Services Information Systems (NEMSIS) data standards for collecting national EMS data. Both E-Licensing and WARDS are secure platforms accessible 20 hours a day.

Department of Transportation

The Department of Transportation ensures the safety of patients, EMS personnel, and the public by inspecting ambulances under Wis. Stat. § 341.085 and Wis. Admin. Code. Ch. Trans 309.

Wisconsin Technical College System

The Wisconsin Technical College System (WTCS) ensures EMS training and continuing education are available throughout the state. Each of the 16 technical colleges within WTCS offers some level of initial EMS training and continuing education, with most offering several levels to meet the needs of their districts. WTCS assists DHS in developing training standards under Wis. Stat. § 256.15(6)(b)2 and shares oversight of training centers within WTCS. Under Wis. Admin. Code § DHS 110.29(2), roles and responsibilities for these shared functions are outlined in a memorandum of understanding between DHS and WTCS.

EMS Board

The EMS Board provides advice and recommendations to DHS on EMS matters. The EMS Board's 13 members are appointed by the governor. EMS Board members come from across the state and different types of EMS systems. A minimum of two members must come from EMS systems serving rural communities under Wis. Stat. § 15.195(8)(b). With this broad base of expertise, the EMS Board provides perspectives from different parts of the EMS system. In addition to general advice and consultation, the EMS Board has several statutory responsibilities outlined in Wis. Stat. § 256.04. Recommendations of the EMS Board to DHS are advisory.

The EMS Board has several standing committees to assist in its work. These committees include both EMS Board members and other interested individuals. The EMS Board selects committee members through an annual application and election process. Committee members then serve for one-year terms. Standing committees include:

- EMS Systems Quality and Data Committee
- EMS Education and Training Committee
- EMS System Management and Development Committee
- Rural EMS Committee
- Human Relations Committee
- Physician Advisory Committee

The EMS Board holds regular quarterly meetings. Meetings are open to the public.

Section 3—Overview of the Wisconsin EMS system

History of the Wisconsin EMS system

The modern EMS system is relatively new. Prior to the early 1970s, the EMS system was largely unregulated, unstructured, and inconsistent both nationally and in Wisconsin. Ambulance service, when and where even available, focused almost entirely on transport. Ambulance personnel provided little to no care even when providing care potentially could have significant impact on patient outcome. Ambulance attendants did not have standardized training or licensing requirements. Ambulances, often converted hearses or station wagons, were ill-suited to providing care even if the attendants had the training to provide it. In 1966, the National Academy of Sciences and the President's Commission on Highway Safety's released the white paper "Accidental Death and Disability: The Neglected Disease of Modern Society" describing the disorganized state of emergency care across the country and calling for implementation of an effective EMS system. This white paper's release is often cited as the beginning of the modern EMS system. The federal Highway Safety Act of 1966 followed, requiring states to adopt highway safety standards including provisions for emergency services. Wisconsin first created an EMS subdivision within the predecessor to the DHS in 1968, only a few years after the release of the white paper. The first federal standards for EMS personnel and ambulances came in the early 1970s.

Following the new federal standards, Wisconsin created its modern EMS system with the passage of 1973 Wis. Act 321 in 1974. The new legislation required ambulance service providers and EMS personnel to be licensed. Under the new act and subsequent legislation throughout the mid-1970s, Wisconsin EMS developed into a structured system providing at least minimum prehospital care and ambulance service throughout the state. New levels of EMS practitioners, with training based on educational standards published by the National Highway Traffic Safety Administration (NHTSA), replaced untrained ambulance attendants. Care levels ranged from emergency medical technicians (EMTs) trained to recognize and treat immediate threats to life to paramedics whose advanced training allowed them to provide emergency medical care previously only available in hospitals. Ambulances were required to conform to the new national safety standards and pass regular state inspections. The new legislation did not distinguish between licensing standards for paid and volunteer personnel. Licensing requirements were uniform for each license level regardless of pay status. The new legislation also did not dictate to local governments the level of service or staffing model they had to provide. Such decisions were left to the discretion of local government. While amended somewhat over the last fifty years, the 1974 EMS legislative framework remains largely intact and still constitutes the bulk of Wis. Stat. ch. 256 governing today's EMS system.

With state standards in place, local EMS systems developed under home rule in accordance with community resources and preferences. Several trends emerged. Larger cities with career fire departments usually took on ambulance service as an additional fire department responsibility. Career fire departments often moved to the paramedic level early on due to larger populations and call volumes. In some areas where hospital ambulance services or independent private ambulance

services already existed, those entities offered EMS to their surrounding communities under contract or other agreement with local government. These systems also frequently used career personnel to provide paramedic level care. While privately owned, these services were still mostly locally owned and operated with strong ties to the community. A handful of counties opted to create county systems, either operating them directly or through a contracted service provider. Most of the state, however, received EMS through small ambulance service providers using volunteer or paid-on-call personnel operating at the EMT level to a single or small group of municipalities. Depending on local preference, such ambulance service providers might be part of the local volunteer fire department, an independent third public safety service of the local government, or a private non-profit organization. This system served the state well for many decades. The broad framework of this system can still be seen today across much of the state. EMS remains very localized even today.

Wisconsin EMS today

Structure of the current EMS system

The framework of the current EMS system is governed by Wis. Stat. ch. 256 and Wis. Admin. Code ch. DHS 110, the current statute and administrative code for EMS certification and licensure. These chapters set the standards for both individuals and service providers. Certification and licensing ensure individuals and service providers meet the state requirements for their levels identified in Wis. Stat. ch. 256 and Wis. Admin. Code ch. DHS 110. Certificates and licenses are issued for a three-year licensing triennium. Certificates and licenses expire on June 30 in the last year of the triennium.

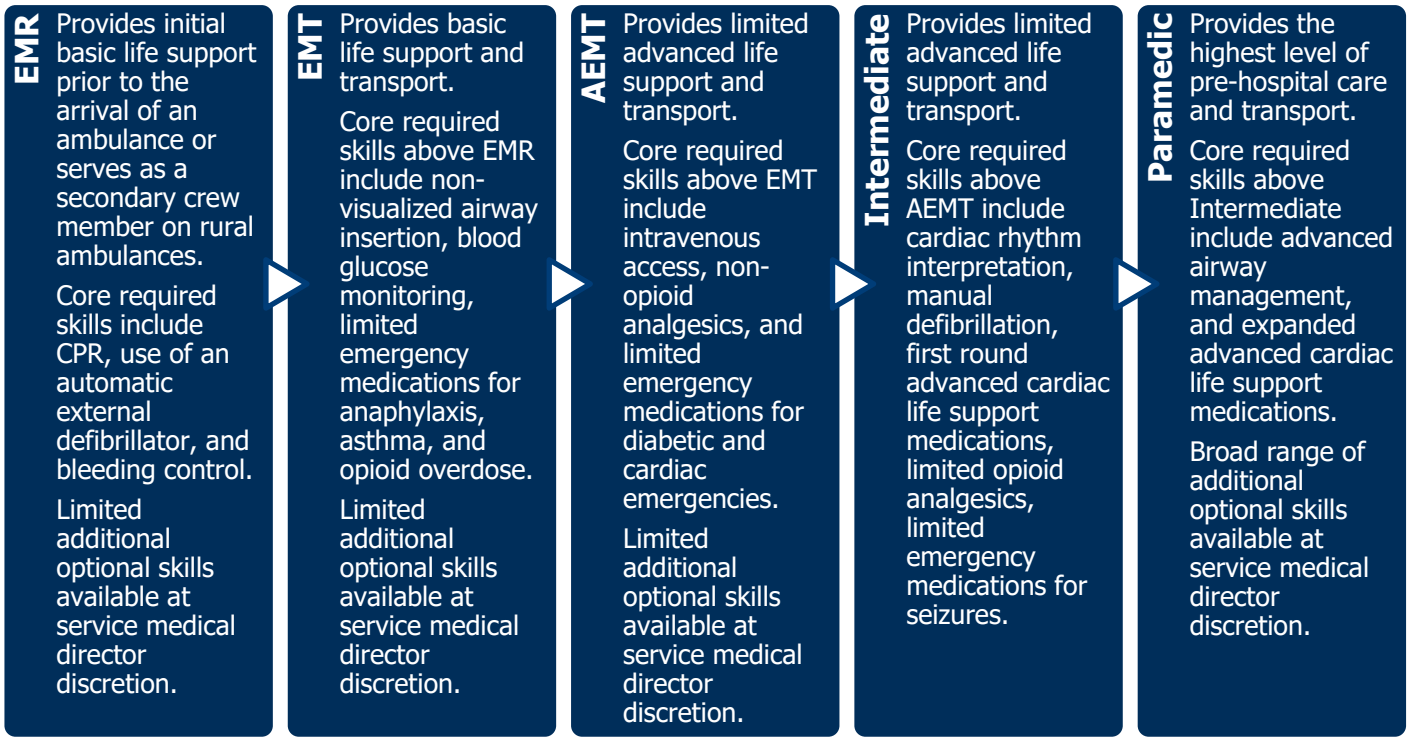
Individual EMS personnel are either certified as EMRs or licensed as one of four levels of EMS practitioners. Service providers use the same levels as individuals, with the exception that all service provider levels are issued as licenses. For both individuals and service providers, the level of certification and licensure sets their scope of practice, except as allowed for certain rural ambulances service providers under Wis. Stat. § 256.15(4m). Current certification and licensure levels include:

- EMR
- EMT
- Advanced EMT (AEMT)
- Intermediate
- Paramedic

Wisconsin's certification and licensure levels generally align with their corresponding level in the EMS National Education Standards and the EMS National Scope of Practice Model published by NHTSA. The one exception is the intermediate level which is based on a previous NHTSA recognized level. Since NHTSA eliminated that level from the EMS National Education Standards over a decade ago, no new intermediate courses have been offered in Wisconsin. Less than fifty intermediates are still left in the system.

EMR and EMT are entry-level courses focused on basic life support. EMR training historically was for individuals providing medical first response prior to the arrival of an ambulance, although since 2015 EMRs may also serve as the second crew member for some rural ambulance service providers. EMTs are trained to provide basic life support. EMT is also the first level able to provide ambulance transportation. AEMT, intermediate, and paramedic training requires the individual to already be an EMT. AEMT and intermediate both provide limited advanced life support interventions, while paramedics provide the highest level of pre-hospital care available. Detailed information on the medications and procedures allowed at each level is available in the Wisconsin EMS Scope of Practice.

Figure 1. Overview of EMS certificate and license levels



Both service providers and EMS practitioners may also hold one of four endorsements on a license:

- Critical care
- Tactical EMS (TEMS)
- Community EMS practitioner
- Community paramedic

Endorsements enable service providers and EMS practitioners to function in specialized practice settings. Critical care endorsement allows practitioners and service providers licensed at the paramedic level to provide additional procedures and medications when providing interfacility transport between health care facilities. TEMS endorsement allows EMS embedded with law enforcement tactical teams to provide medical care during high-risk law enforcement operations. Community EMS practitioner and community paramedic endorsements allow practitioners and service providers to perform health care services outside of traditional EMS roles. These include assisting

patients with resource navigation, compliance with discharge instructions after leaving the hospital, leading injury prevention programs, and addressing other gaps in the local health care system.

Initial and continuing education is available across the state through a network of certified EMS training centers. All 16 technical colleges within WTCS are certified as initial training centers and offer at least some levels. Additional training centers outside of the WTCS are run by local or county government, service providers, hospitals, and private enterprises. DHS also allows for alternative continuing education options for triennial renewal requirements better meet the needs of busy EMS personnel, especially volunteers and paid-on-call personnel in rural areas.

Before individual EMRs and EMS practitioners can practice, they must credential with a service provider under Wis. Admin. Code § DHS 110.11 and 110.52. This credential is an agreement between the individual, the service provider, and the service provider's physician medical director ensuring that the individual will follow the medical care protocols and orders of the service medical director. The credentialing process ensures that all emergency medical responders and EMS practitioners volunteering or employed within the EMS system have physician oversight.

Service providers are licensed for the type of services they provide in addition to their license level. These services are described in the service provider's operational plan. Service providers are licensed either as an ambulance service that provides patient transport or as a non-transporting service that provides first response and emergency medical care before the arrival of an ambulance. Ambulance service providers additionally are classified by the type of transport they offer. Ambulance services providing emergency response to a dedicated primary service area are licensed as 911 transporting services. Ambulance service providers that provide transport between health care facilities are licensed as interfacility services. Service providers licensed at higher license levels may also be licensed to provide intercept services to other ambulance service providers, enabling patients to receive advanced care in the field even when not available through their primary ambulance service provider. Service providers can generally be licensed with any combination of license level and type of service, except EMR-level service providers may not be licensed as transporting services. Service providers may be licensed for multiple functions.

All portions of the state have access to emergency ambulance service through the 911 system. In some areas, stand-alone EMR service providers or other non-transporting service providers deliver emergency medical care before the arrival of an ambulance. Service providers support one another through locally approved coverage and mutual aid agreements when they need additional resources. Additionally, air medical services are available, weather permitting, to provide advanced care and rapid transport to the state's trauma centers.

As in the original system, decisions about how to provide EMS are handled at the local or county level. Local decision makers therefore continue to decide what license level, staffing model, and type of EMS organization are appropriate to local needs within the broader framework of Wis. Stat. ch.

256 and Wis. Admin. Code ch. DHS 110. Also, as in the original system, certification and licensing standards for both individuals and service providers remain largely uniform regardless of the pay status of personnel or the area that a service provider covers.

Personnel data

Data analysis of the EMS personnel is challenging as the composition of EMS work force is constantly changing. Approximately 1,500 new individuals enter the EMS system annually through in-state education or reciprocity from other states. Individuals also leave the system throughout the triennium. However, because certificates and licenses only expire once every three years, losses within the system are only captured at the end of each licensing triennium. When looking at individual EMS certification and licensing data, this situation gives a false impression of the size of the EMS workforce, especially towards the end of the triennium when the number of uncaptured losses is highest. It also can lead to overexaggeration of the loss when three years of attrition are suddenly captured at the end of the triennium. The recent transition from a two-year to a three-year licensing cycle has made these differences even more pronounced by adding both another year of growth at the peak of the cycle and another year's worth of attrition at the end. As of July 1, 2025, the EMS system had 21,855 certified EMRs and EMS practitioners two years into the current renewal cycle.

A more comprehensive analysis of service provider data is available in Appendix A.

Figure 2. EMS personnel by certification or license level on July 1, 2025

Level	Number of Individuals	Percent of Total EMS Personnel
EMR	3,869	17.7%
EMT	9,855	45.1%
AEMT	1,996	9.1%
EMT-Intermediate	46	0.2%
Paramedic	6,089	27.9%
Total	**21,855**	**100%**

Because EMS certification and licensing numbers are constantly changing, the numbers represent the specific point in time the information was obtained. E-Licensing does not have the capability to reproduce data for previous points in time on demand. The date selected, July 1, 2025, is two years since the end of the last renewal cycle ended on June 30, 2023.

Service provider data

Data regarding service providers has improved over the last several years. Additionally, while service provider numbers also fluctuate, they tend to be more stable than individual numbers. All service providers are required to maintain an operational plan detailing how they will provide emergency medical services. Prior to 2023, the operational plan process was completed in paper. Despite collecting a large amount of service data through operational plans, lack of a centralized data repository prevented service provider data from being easily reported and analyzed. The EMS Section

began a multiyear initiative in 2019 to improve its service provider data. While still not complete, this project has resulted in better and more data regarding service providers.

Figure 3. Service provider by license level on July 1, 2025

Level	Number of Service Providers	Percentage of Total Service Providers
EMR	335	40.7%
EMT	146	17.8%
AEMT	78	9.5%
EMT-Intermediate	4	0.5%
Paramedic	259	31.5%
Total	**822**	**100%**

Because EMS certification and licensing numbers are constantly changing, the numbers represent the specific point in time the information was obtained. E-Licensing does not have the capability to reproduce data for previous points in time on demand. The date selected, July 1, 2025, is two years since the end of the last renewal cycle ended on June 30, 2023.

In addition to license level, service providers may be classified by other NEMSIS or state designated factors regarding their structure. Common ways of classifying service providers include:

- **Type of service**—Type of service refers to the activities a service provider is licensed to provide. All service providers will have at least a primary type of the service they are licensed to provide. Some service providers are also licensed for other types of service. Service providers may be licensed for 911 transporting, 911 non-transporting, interfacility, intercept, air medical, TEMS, CEMS, or a combination of those types.
- **Organizational type**—Organizational type refers to how the service provider is structured or owned. Service providers may be classified as fire departments, governmental non-fire, hospital, private non-hospital, or Tribal.
- **Organizational status**—Organizational status refers to how service providers compensate their members. Service providers are classified as volunteer, non-volunteer, or combination/paid-on-call.
- **Organizational tax status**—Organizational tax status refers to whether a service operates for profit. Service providers may be classified as for profit, not for profit, or government.

Prior to the recent data improvement initiative, only some of these fields were readily accessible within the E-Licensing system limiting analysis of service providers beyond licensure level. While some gaps and limitations exist, better collection in these fields allows for a better picture of the composition of the current EMS system.

A more comprehensive analysis of service provider data is available in Appendix B.

911 coverage overview

One of the primary functions of the EMS system is assuring response to 911 calls. However, due to the localized and fragmented nature of the EMS system, data on how service providers respond to 911 has been limited. Over 300 ambulance service providers and 350 non-transporting service providers are licensed to provide 911 response. These service providers include all license levels, organizational types, organizational statuses, and organizational tax statuses. The EMS response a caller receives may differ significantly from jurisdiction to jurisdiction based on how EMS is structured. The EMS Section attempted to do a comprehensive analysis of how primary 911 coverage is provided across the state in preparation for this plan. While the following information gives some insight into how 911 response is provided, limited records and inconsistent reporting by municipalities still leaves gaps in knowledge about 911 coverage.

Almost all cities and villages reported utilizing a single ambulance service provider for their primary 911 transporting service. Less than a half dozen cities and villages split ambulance coverage for their municipalities between multiple ambulance service providers. Tracking how their populations received ambulance service is thus relatively easy because the ambulance service coverage area boundaries were the same as those of the municipality. The resulting population coverage data for cities and villages therefore closely aligns with the populations for cities and villages overall.

Towns, however, are more likely to split ambulance coverage between several ambulance service providers, with each ambulance service provider covering a distinct geographic area of the town. Approximately a quarter of towns use more than one ambulance service provider. When calculating coverage with multiple service providers, it was common for the total coverage reported to either over or underrepresent the town's actual population. Additionally, ambulance service providers were less likely to have coverage information attested by town officials, resulting in greater reliance on self-reported coverage data. Overall, this led to a slight overrepresentation of ambulance coverage populations for towns compared to the population living in towns overall. This, in turn, led to a similar slight overrepresentation in the overall state data. Despite this problem, several trends regarding 911 coverage are evident.

The population data revealed an EMS system more reliant on paramedic level care and career personnel than anticipated. At the time of the review, paramedic level ambulance providers (including those with critical care endorsement) constituted approximately 45.9% of all ambulance service providers. However, paramedic level ambulance service providers covered 83.3% of the state's population. Career services constituted approximately 32.3% of ambulance service providers but provided primary 911 coverage for approximately twice that share (66.9%) of the state's population. Combination and paid-on-call accounts for the largest percentage of ambulance service providers (54.1%) but protect only about 30.1% of the state's population. Volunteer ambulance service providers, while accounting for 13.6% of all ambulance service providers, protected less than 4% of the state's population. This trend towards paramedic level care and career staff was also statewide.

Despite regional differences on exact proportions, these majorities were common across each of the state's seven EMS regions.

In terms of what type of organization provides ambulance service, there was significantly more regional variation. Fire-based ambulance service providers constituted the most common service organizational type (44.1% of all ambulance service providers). Fire departments also provided ambulance service to the largest portion of the state's population (64.0%). Fire-based ambulance service, however, is not evenly distributed across the state. Fire-based EMS is instead concentrated in larger cities throughout the state and in certain geographic areas, notably the state's northcentral and southeast EMS regions. Fire-based ambulance service, for example, protected over 94% of the population in the heavily urbanized southeast region but covered less than half of the population in the northwest region, southwest region, and even the relatively urbanized Fox Valley region. Governmental non-fire, private and hospital ambulance service providers were more common or even provided most ambulance coverage by population elsewhere in the state. The southwest region, which had the lowest percent of the population protected by fire-based ambulance service (6.5%), had large percentages of the population protected by non-hospital private (74.3%) and governmental non-fire (16.8%) ambulance service providers.

Population, however, is not the only consideration in 911 coverage. Geographic area is also a consideration. Unfortunately, the EMS Section does not have access to specific information on geographic coverage. Coverage data by municipalities suggests there are likely differences between ambulance coverage by population and by area. While nearly two-thirds of the state's population is protected by career service providers, only 44.3% of all municipalities reported receiving all or a portion of their ambulance coverage from career service providers. The number of municipalities reporting whole or partial coverage by volunteer service providers (17.4%) and combination and paid-on-call service providers (50.9%) was much higher than their population coverage figures.

The EMS Section conducted a similar compilation of non-transporting service data. Non-transporting services, unlike ambulance service providers, do not have the same reporting requirements as ambulance service providers. The EMS Section therefore relied primarily on self-reported information from service provider records. Use of stand-alone non-transporting service providers is not universal. In terms of population covered, only about a quarter of the state's population (25.9%) live in communities serviced by stand-alone non-transporting service providers. In the remainder of the state, first response either occurs through the ambulance service provider (for example, fire-based ambulance service providers that also send the nearest fire apparatus with the ambulance) or does not occur at all. As with ambulance service, the population data for non-transporting service providers does not account for area. As over a third of villages and towns are covered by non-transporting service providers, non-transporting service providers are likely to service a larger percentage of the state by area than by population. As with ambulance service providers, fire-based non-transporting service providers protect the largest number of people (73.0%). Unlike ambulance

service providers, non-transporting service providers are significantly more likely to be volunteer (74.8% of all non-transporting service providers compared to 13.2% of ambulance service providers).

When reviewing the ambulance and non-transporting coverage data, the most significant finding is the diversity of EMS system structure across the state. With the number of variables available when structuring an EMS system, there are few statewide commonalities. Additionally, regional and county-level preferences for different types of EMS systems are strong. For example, fire-based ambulance systems are nearly universal in the southeastern portion of the state, but nearly non-existent in areas along the state's western border. There are significant differences in use of fire-based ambulance service providers even between southeastern Wisconsin and the also relatively urbanized and densely populated Fox Valley. Likewise, volunteer ambulance service providers remain relatively common in the rural southwestern corner of the state, but similarly rural counties in parts of the center of the state have none left. These regional differences make statewide discussions of problems and solutions challenging due to different perspectives based on local systems.

A more comprehensive analysis of service provider data is available in Appendix C.

Wisconsin EMS in transition

Numbers challenges

EMS remains unique as the only portion of the health care system where volunteer and paid-on-call practitioners constitute a large segment of the workforce. Despite great dedication to EMS, volunteer and paid-on-call practitioners' ability to stay in EMS may be limited by competing needs of family, work, and other community service. EMS also has some of the shortest initial training requirements and lowest entry costs among health care professions. An initial EMT class can be completed part-time in a matter of months. Even most paramedic programs can be completed in a year or less. This is in sharp contrast to other health care professions, like nursing, that require an associate degree or higher with the corresponding investment in education. EMS remains a health care profession that individuals can enter, work for a short time, and leave without losing significant investment. EMS also has the challenges of operating in a 24/7 working environment with high stress, physically demanding work, and relatively low pay (or no pay in the case of volunteers). Attrition within EMS therefore is—and has historically always been—high compared to other health care professions.

The result is a system with high turnover. In a typical year, around 1,500 new individuals enter the EMS system. In the former two-year licensing period, 2,500 to 3,000 individuals would not renew in an average biennium. The first three-year cycle, which ended in 2023, had a similar proportional loss. Maintaining the number of EMS professionals in the system depends on keeping this balance of new and outgoing personnel.

In 2023, the Wisconsin Office of Rural Health published *The Reliability of Wisconsin's 911 Ambulance Response*. This report, based on a survey of ambulance providers, supports anecdotal concerns

circulating within Wisconsin EMS for years that the delicate balance of personnel is strained. Specifically, the report notes that within the preceding twelve months, 41% of ambulance service providers reported periods where there were inadequate personnel to fill their ambulance staffing schedule, 78% reported responding to another jurisdiction because that jurisdiction could not staff its ambulance, and 41% reported six or fewer members provided 80% or more of their staffing hours.[1]

Between 2016 and 2023, the number of new individuals entering the EMS system generally remained somewhat consistent or even increased year-to-year. In 2020, the major outlying year, the training system briefly shut down during the middle of spring semester due to the COVID-19 pandemic. A similar abnormal peak in 2022 may be explained in part by training center activities largely first returned to normal that year following the end of COVID-era restrictions.

Figure 4. Initial and reciprocity applicants 2016-2023

Applications	2016	2017	2018	2019	2020	2021	2022	2023
Reciprocity	309	336	344	380	376	399	430	442
Initial	1,279	1,259	1,369	1,332	1,148	1,310	1,520	1,394
Total	**1,588**	**1,595**	**1,713**	**1,712**	**1,524**	**1,709**	**1,950**	**1,836**

Unfortunately, the number of certified and licensed EMS personnel at the end of each of the last two renewal periods dropped compared to the preceding renewal period. This trend was true for all certification and licensure levels except paramedic.

Figure 5. EMS Personnel Following Renewals 2018-2023

Certificate or License Level	2018	2020	2023
Emergency medical responder	3,058	3,005	2,633
Emergency medical technician	7,794	7,555	7,407
Advanced emergency medical technician	2,230	2,018	1,764
Intermediate	128	94	47
Paramedic	4,611	4,729	5,221
Total	**17,821**	**17,401**	**17,072**

Losses occurred despite efforts to reduce barriers to renewal during the same period. The EMS Section removed all hour limitations on online refresher education in 2016. Since this change, EMRs and EMS practitioners can complete their refresher training requirements entirely through on-demand online education by any Commission for Accreditation of Pre-Hospital Continuing Education (CAPCE) provider or Wisconsin-certified training center except for some parts of CPR and advanced cardiac life support recertification. The EMS Section also expanded the ability to use service provider in-house training to apply towards refresher requirements for renewal if approved by the service director and service medical director to incentivize participation with a service provider and reduce duplicative local and state requirements. Additionally, following the passage of 2017 Wis. Act 350 and the

[1] Wisconsin Office of Rural Health. (2023). *The Reliability of Wisconsin's 911 Ambulance Response. Wisconsin Office of Rural Health*. https://worh.org/wp-content/uploads/2023/03/EMS-Reliability-Report_March2023.pdf

transition from a biennial to a triennial renewal cycle, the ratio of refresher hours to year has decreased for all levels. These changes reflect a commitment to providing EMS personnel, especially volunteer and paid-on-call personnel, with refresher options that can better fit into their availability while still maintaining necessary standards for refresher education.

Beyond the total number of individuals certified and licensed, the number of EMS personnel choosing to volunteer or work within the EMS system affects the number of people available to service providers. EMS personnel are not required to be affiliated with a service provider to obtain or renew a certificate or license. Wis. Stat. §§ 256.15(5)(g) and (8)(g) specifically bar any such requirement. As of July 1, 2025, 21.6% of all EMS personnel did not have an active credential with a Wisconsin service provider. These individuals were thus not volunteering or employed with a Wisconsin service provider in a patient care role within the EMS system. The percentage of individuals without an active credential was most pronounced among individuals licensed at the EMT level (29.2%), individuals between the ages of 20 and 29 (29.6%), and individuals under the age of 20 (42.9%). Participation in the EMS system was higher among advanced life support providers (intermediates and paramedics) and individuals 30 or older. The lack of participation in the EMS system among individuals under 30 and among individuals licensed at the EMT level are especially troublesome as both constitute significant segments of the available EMS workforce.

Service provider changes

In addition to the changes in EMS personnel, the last decade has brought changes to service providers. Since June 30, 2012, approximately 200 service providers have not renewed or requested to surrender their service licenses. Changes within the EMS system are not unusual. In every licensing cycle, approximately 10 to 25 service providers choose not to renew. It is also common for a similar number of new service providers to come into the system in the same period. Much of this normal change comes from EMR service providers. With looser licensing regulations and no 24 hour a day staffing requirements designed to make it easier for rural areas to start EMR service providers, these tend to be less stable than ambulance service providers. Approximately 120 of the non-renewing or closing service providers over the last twelve years, however, were ambulance service providers. While this number is startling on its face, a deeper look presents a more nuanced picture of evolution within the EMS system to meet changing conditions.

In only approximately 40% of these closures did the ambulance service provider simply go out of business. In the remaining approximately 60% of ambulance provider closures, the closure was due to the ambulance service provider going through a consolidation, merger, or internal restructuring to more effectively provide ambulance services. Under Wis. Stat. § 256.15(5)(e), EMS licenses are not transferable. Making such structural changes therefore often requires the issuance of a new license or moving all operations under an existing entity, after which previous or redundant licenses can be surrendered or not renewed. These previous or redundant licenses are tracked as service provider closures. In most of these cases, however, ambulances services continued through the same entity (albeit in a different form) or a successor. These changes largely occurred through three forms:

- **Public sector consolidation**—As municipalities continue to look for ways to perform services more efficiently, some consolidated their EMS with neighboring municipalities. This trend has been especially common among fire-based systems, where the high cost of firefighting apparatus and equipment can make sharing resources attractive for some communities. About half a dozen new fire-based ambulance service providers were created from the consolidation of existing fire-based ambulance service providers since 2012. Several other municipalities simply merged their ambulance service directly into that of their larger neighbors without creating a new entity. In a handful of instances, an entire town itself was simply annexed into a neighboring city or village, eliminating the need for two separate ambulance providers.
- **Private sector mergers**—The private ambulance industry has also seen a similar merger and acquisition trend mirroring that in the public sector. Sometimes these mergers and acquisitions result from a larger merger within the health care industry, such as when two hospitals systems with ambulance services merge all operations—including EMS—into a single system. In other cases, ambulance service providers themselves have purchased or acquired other existing ambulance service providers. As with mergers and acquisitions in other health care sectors, mergers and acquisitions in the ambulance industry have multiple causes, ranging from breaking into a new market, to acquiring a principal competitor, or to attempting to capitalize on economies of scale to better compete in an increasingly competitive market.
- **Internal reorganizations**—The last decade has seen several services reorganize their operations to streamline licensure or due to larger changes in their organizational structure. Historically ambulance service providers operating multiple stations commonly licensed each station individually. While this method of licensing allowed for more variation in operations, separate personnel rosters, even different license levels within an entity's ambulance operations, it also requires more work to administer multiple licenses, operational plans, and credentialing requirements. Merging independently licensed stations under a single license has been an industry trend over the last decade. Additionally, over the last decade several not-for-profit volunteer fire companies reorganized as part of a municipality. The decision to reorganize to become part of a municipality is driven by a combination of factors including greater access to municipal resources, the need to pay for paid-on-call or career staff, or to bring the organization under municipal liability protection.

Regardless of whether the change was due to public sector consolidation, private sector mergers, or internal reorganization, ambulance service typically continued without any significant disruption. There frequently was little outward difference to the public, as the service leadership, personnel, facilities, equipment, and operating practices often remained the same. These changes were also made intentionally by the ambulance service providers themselves or their municipalities or owners, frequently with a goal of greater efficiency and sustainability. In that sense, the resulting loss of predecessor entities represents the affected service providers' and communities' adaptation to change rather than simply a loss of license.

Change, however, has also meant loss. Of the 40% of ambulance service providers that closed outright, rural 911 services and small independent non-emergency interfacility transfer services were especially hit. The latter group, once a bedrock of interfacility transfers, has contracted substantially and all but disappeared in some markets increasingly dominated by large ambulance service providers. It is important to note, however, that in every situation where the closing ambulance service provider had a designated 911 primary service area, another ambulance service provider took over that 911 service area ensuring continued access to emergency response.

To the future

The challenges facing EMS in Wisconsin are not unique, nor will there be easy solutions to them. Additionally, many of the difficult questions facing individual EMS systems, like recruiting, staffing, funding, and daily operations are ultimately the decisions of their local government or private sector owners. Supporting the growth of the EMS system and the EMS workforce, while staying in its proper role and still maintaining the standards Wisconsinites expect from their EMS, remains a DHS priority. Throughout OPEHC, DHS staff work to continually improve the certification and licensing of both individuals and service providers, enforce compliance, administer aid to local EMS programs, improve EMS through data collection and data-driven decisions, and link EMS to the wider state preparedness and health care system.

Section 4—Accomplishments: 2024–2025

State plan evaluation

In the last state plan, OPEHC set goals for the coming years spanning across multiple areas within the EMS program. OPEHC made significant progress towards achieving these goals and accomplished most. Principal goals were:

- Implementation of FAP expansion under 2023 Wis. Act 19 and the 2024-2025 state budget.
- Expanding EMS data collection and analysis through improving the quality of data submitted to WARDS, creating data dashboards to increase quality assurance resources, expanding EMS data resources on the DHS website, and migrating WARDS to the NEMSIS version 3.5 standard.
- Updating the E-Licensing system by moving the operational plan process into an electronic application, updating all renewal applications, increasing the use of trackable communications, and updating EMR certification to conform to changes under 2023 Wis. Act 12.

The EMS Section, in partnership with the OPEHC's Grants and Administration Section and the EMS Board, successfully implemented FAP changes in SFY 2025. This included updating the distribution formula in consultation with the EMS Board, redesigning both the application and expense report within the EMS Section's E-Licensing system to incorporate the statutory changes and to make completing both processes easier for service providers. The EMS Section issued funds to 495 service providers during the SFY 2025 FAP, 35% of which were non-transporting service providers.

The Data and Systems Section, in cooperation with the EMS Section, made significant progress on increasing EMS data resources. The migration to the NEMSIS version 3.5 standard began in late 2023. All service providers transitioned to the new standard by early 2024. The Data and Systems Section released an interactive service provider map and reports on individual and service provider licensing statistics. EMS and trauma data were combined to produce a report on falls. With the transition to NEMSIS version 3.5 now complete, the Data and Systems Section is releasing a report on statewide WARDS data under the new standard. Both the EMS Section and the Data and Systems Section continue to look at opportunities to better share statewide EMS data.

The EMS Section successfully implemented the planned improvements to the E-Licensing system. The EMS Section created new applications for both initial EMR certification and EMR certification based on armed forces training incorporating the changes to eligibility under the statute. The operational plan process was successfully transitioned from a paper process to the new electronic system. Renewal applications for the 2026–2029 renewal period have been designed, built, and are ready for the start of the renewal application period in early 2026.

Accomplishments beyond the state plan

In addition to the goals set forth in the last state plan, OPEHC EMS Section staff accomplished other significant achievements since the last plan. Notable accomplishments include:

- **Community EMS**—The EMS Section partnered with the Wisconsin EMS Association (WEMSA) to host a community EMS forum and track at WEMSA's 2024 annual conference in Green Bay. This opportunity, funded by a grant, was part of the EMS Section's general efforts to support and create awareness of community EMS programs.
- **Curricula—**The EMS Section, in partnership with the WTCS, released updated curriculum for the emergency medical responder, emergency medical technician, and advanced emergency medical technician levels. Wisconsin curriculum had last been revised between 2011–2013. Since that time the National EMS Educational Standards on which they are based have changed. In addition, there have been multiple changes to Wisconsin EMS scope of practice in the ensuing decade. The new curricula bring EMS training back into alignment with both national standards and current scope of practice, ensuring the new generation of EMS personnel have the necessary training to meet the needs of our communities.
- **EMS Awareness Campaign**—The EMS Section conducted a media awareness campaign of opportunities for volunteer service or careers in EMS. The grant-funded campaign featured targeted internet advertising in the summer and fall of 2024, with the goal of encouraging interested individuals to reach out to service providers or training centers in their area. All advertising featured real Wisconsin EMS personnel describing why they chose and stay in EMS.
- **EMS Communications Plan**—The EMS Section, in partnership with the Department of Transportation and with input from the State Interoperability Council, reviewed the EMS Communications Plan. This plan, listing radio and other telecommunications recommendations for interaction with hospitals and interoperability with other emergency services, was last published in 2019.
- **Helicopter EMS Utilization Guidelines**—The EMS Section released updated Helicopter EMS Utilization Guidelines. This was a joint project between the EMS Section, the Data and Systems Section's trauma program, the Physicians Advisory Committee, the State Trauma Advisory Council (STAC), the EMS Board, and the Wisconsin Air Medical Council.
- **Mass Casualty Incident Planning Guide**—The EMS Section updated the Mass Casualty Incident Planning Guide as a resource to service providers. Important updates included recommendations on triage systems based on recommendations from the EMS Board and STAC, expanded pediatric resources in partnership with EMS-C, and updates on patient tracking resources available through the Data and Systems Section.
- **Medical Director Course**—In cooperation with the Physicians Advisory Committee, the EMS Section updated courses that could be used to meet the service medical director course requirement under Wis. Admin. Code § DHS 110.49(1)(f). Additionally, the state EMS director created a web-based Wisconsin-specific component, the first revision in over 10 years.
- **Partner communications**—The EMS Section curated an email list through the GovDelivery platform to share EMS-related information in 2024. The GovDelivery list allows for another pathway to share non-essential information to interested individuals inside or outside the EMS system. The new list also allows the EMS Section to limit communications through its E-licensing system to essential communications about service providers of individual licensure and certification.

- **Pediatric Emergency Care Coordinator Support**—EMS-C hosted quarterly virtual meetings for service provider and hospital pediatric emergency care coordinators. Each meeting included an educational component in addition to EMS-C program updates.
- **Prehospital Pediatric Readiness Assessment**—Over 200 Wisconsin service providers completed the National Prehospital Pediatric Readiness Assessment through EMS-C. This was part of a national effort to gauge EMS systems' abilities to treat and transport pediatric patients.
- **T-CPR**—The EMS Section, with assistance from the OPEHC Grants and Administration Section, awarded $60,899.27 to public safety answering points for training dispatchers to prove instructions to 911 callers on performing cardiopulmonary resuscitation. All application and reporting materials were newly created for SFY 2025.

Section 5—Goals and initiatives: 2026–2027

Licensing

The EMS Section certifies or licenses ambulance service providers, other service providers, EMRs, and EMS practitioners under Wis. Stat. §§ 256.15(5), (6), (7), and (8). The EMS certification and licensure cycle moved from a biennium to a triennium following passage of 2017 Wisconsin Act 350. All certificates and licenses expire on June 30 in the last year of the triennium. The last renewal period as of development of this plan ended on June 30, 2023. The next renewal will end on June 30, 2026.

Certification and licensing of EMS personnel and service providers is the EMS Section's core function. The EMS Section's individual licensing team processes approximately 2,500 training center permits and 2,500 certification and licensing applications each year. Its regional coordinators review hundreds of service provider operational plans, medical protocols, and other service provider applications. A summary of the EMS Section's certification and licensing activities is listed in Appendix D.

The last two years saw a major change to the certification process. 2023 Wis. Act 12 made several changes to EMR certification effective as of January 1, 2024. The EMS Section created new applications for both initial EMR certification and EMR certification based on armed forces training incorporating the changes to eligibility under the statute. Both applications were successfully released in January 2024. The EMS Section also updated its verification of licensure and verification of education forms in 2024 to speed determinations on whether EMR certification standards in other states are substantially similar to Wisconsin when evaluating applicants for the reciprocity certification under Wis. Stat. § 256.15(8)(f). At this time, there is still insufficient data to determine long-term impact the changes will have on EMR numbers.

The EMS Section is continually looking for ways to enhance its certification and licensing abilities to better serve our students, certificate holders, licensees, and service providers. Rapid processing of eligible certification and licensing of applicants helps reduce the time from individuals completing training to the time they can provide emergency medical care in the field with a service provider.

Efficiency in the certification and licensing process takes increased importance at the end of each licensing triennium when all EMS certificates and licenses expire. The first year of this plan, 2026, is a renewal year. All EMS certificates and licenses for individuals, service providers, and training centers will expire on June 30, 2026, unless renewed. Individuals and service providers rely on the EMS Section to promptly and accurately process thousands of applications during the approximately four-month renewal application period to ensure their continued ability to serve the EMS needs of their community. Planning for the 2026–2029 renewal period began before the previous 2023–2026 cycle came to an end on June 30, 2023. Additionally, the EMS Section must be able to still fulfill its normal functions while renewing an estimated 17,000 individuals and 800 service providers. Much of the EMS Section's ability to absorb this level of work is due to the EMS Section's E-Licensing system.

After several earlier attempts with electronic licensing management systems yielded mixed results, the EMS Section transitioned to its current E-Licensing system in 2008 for its individual certification and licensing processes. This change gave individuals direct access to their certification and licensing records, the ability to submit applications electronically, and the ability to do limited functions without the need to contact EMS Section staff. Some service provider licensing functions were moved into E-Licensing at about the same time, though most service provider applications and forms remained paper-based. Efficiencies gained through use of E-Licensing have enabled the EMS Section to help absorb additional workload while keeping processing times minimal.

The EMS Section is in the middle of a multi-year project to enhance the capabilities of the E-Licensing system. After nearly two decades, the E-Licensing system requires updates to continue to meet the needs of our applicants. Several of the original individual licensing applications from the 2008–2011 period are still in use and lack the greater functionality of newer applications. Additionally, the EMS Section still has a few remaining individual licensing functions conducted through paper processes. These processes are more difficult to track and slower to process. The EMS Section has therefore begun to review and rebuild all individual applications to take full advantage of new features within E-Licensing and to give all applications a consistent look and flow for the end user.

Building on the success of the transition to E-Licensing for individual processes, the EMS Section also began a major initiative to transition to most service provider licensing functions to E-Licensing in 2023. The first step of this process was to transition the operational plan process from paper to the E-Licensing system. Over 150 service providers have updated their operational plans in two years since this transition. The EMS Section is now working to transition its other paper-based service provider forms and applications to E-Licensing.

Beyond the internal efficiencies in tracking and recordkeeping, expanded utilization of E-Licensing for service provider functions enables the EMS Section to grant more autonomy to EMRs, EMS practitioners, service medical directors, and service providers. When making changes, the EMS Section has looked at which functions truly need review or manual processing by section staff and where there were opportunities to increase local control. As an example, services seeking to grant access to their personnel to have additional permission within the service provider's E-Licensing and WARDS accounts formerly were manually processed by section staff. The new applications will allow service directors to assign their personnel to these roles electronically through the E-Licensing system in real time. While many processes will still require review by section staff, automating those that do not free section staff to focus on those that do and allow service directors to perform them as needed in the 24/7 environment of EMS.

Goal: Prevent disruption to the EMS system during the 2026–29 renewal process.		
Objective	**Timeline**	**Benchmark**
No inadvertent disruption of ambulance service due to unintentional non-renewal of an ambulance service provider license.	4 months	All ambulance service providers licenses are renewed unless the EMS Section receives written notification for the service provider of its intention not to renew.
Individual applicants for certification and licensing renewal are promptly reviewed and issued.	4 months	All 2026–2029 individual renewal applications are reviewed and issued in less than the period allowed under administrative rule.
Individuals who fail to renew their certifications or licenses have rapid access to late renewal or reinstatement.	1 year	The application processes for both late renewal and reinstatement are developed, tested, and ready in advance of the end of the regular renewal period.

Goal: Enhance the efficiency and accountability of certification, licensure, and reporting processes through greater utilization and improvements to the E-Licensing system.		
Objective	**Timeline**	**Benchmark**
Ensure consistency in appearance, content, workflow, and functionality across applications and forms.	1 year	All forms and applications within the E-Licensing system greater than three years old are redesigned to align with current standards of functionality.
Seek opportunities for transitioning manual processes into the E-Licensing system or other electronic applications.	2 years	Transition of 50% the paper-based processes still existing as of July 1, 2025, to E-Licensing.
Develop a program for enhanced tracking of applications and forms.	5 years	Scheduled processing reports are in place within E-Licensing for quality assurance of all application and form processing.

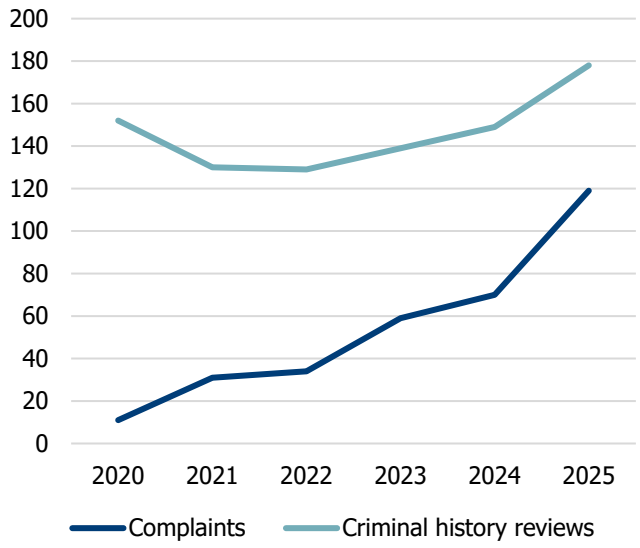
Compliance

The EMS Section investigates complaints regarding ambulance service providers, emergency medical responders, EMS practitioners, training centers, and medical directors under Wis. Stat. § 256.08(4)(h). Wis. Admin. Code §§ DHS 110.53–54 outline the EMS Section's authority to investigate and reasons to take enforcement actions. Complaint investigations may include interviews, documentation review, site visits, and vehicle and equipment inspection. Enforcement actions, if appropriate, may be taken against individuals and service providers after consulting with the EMS Board and the state EMS medical director. The compliance team also reviews applicants with criminal history to ensure compliance with Wis. Stat. §§ 256.15(6)(a)1 and 256.15(8)(b)2. Criminal history is reviewed on a case-by-case basis and is subject to Wis. Stat. §§ 111.321, 111.322, and 111.335.

The EMS Section's compliance workload increased substantially within the last several years. The number of criminal history reviews, while fluctuating slightly from year to year, grew slightly since 2021. The annual number of complaints the EMS Section received in the same period, however, more than tripled. Complaints are not an area of growth that the EMS Section wants to see as each complaint represents an individual who believes EMS failed to meet the accepted standard in their care. A primary goal in compliance is therefore trying to prevent compliance issues before they occur.

The EMS Section's efforts to reduce compliance issues are complicated by multiple factors outside of its control. Routine clinical care oversight to identify and prevent potential problems, for example, is a responsibility of the local service providers and their service medical directors. Likewise, the EMS Section has no direct control to prevent an EMR or EMS practitioner from committing a criminal act. The EMS Section can, however, attempt to create greater awareness of requirements and responsibilities so that service providers and EMS personnel understand the standards surrounding their certification or licensure. In that way, service providers and EMS personnel can hopefully avoid actions that may require administrative action.

Figure 6. Compliance functions 2020-2025



The ongoing project to upgrade E-Licensing offers the EMS Section a unique opportunity to address familiarity with requirements across all parts of the system. New applications and forms for both individuals and service providers now include more references to the associated provisions of statute and administrative rule so that applicants can see and familiar themselves with the applicable standards before entering or starting a new role within the EMS system.

Goal: Reduce the compliance issues through increased awareness of individual and service provider responsibilities and requirements.		
Objective	**Timeline**	**Benchmark**
Create awareness of professional responsibilities at the earliest stage in the application process.	2 years	All licensure, certification, and permit applications include statutory and administrative code provisions pertinent to professional responsibilities associated with that license, certificate, or permit.
Increase awareness of service provider responsibilities through the operational plan process.	5 years	Double the proportion of service providers with a current operational plan on file.

Training

The EMS Section sets standards for all organizations that offer training to EMRs and EMS practitioners on what topics should be included in initial training and continuing training under Wis. Stat. § 256.08(4)(e). The EMS Section also certifies training centers and instructors under Wis. Stat. § 256.15(9) and Wis. Admin. Code § DHS 110.18, 110.27, and 110.28. The EMS Section partners with WTCS for several of these functions.

One major change in training since the last plan was curriculum revision. Wisconsin last revised its curriculum for all levels between 2011 and 2013. That prior revision was in response to the NHTSA's release of the National EMS Education Standards in 2009. Emergency medical care, however, is ever-evolving. NHTSA updated the National EMS Education Standards in 2021 to incorporate changes in medical practice over the last decade. Additionally, Wisconsin EMS scope of practice grew significantly between the last curricula revision, especially at the emergency medical responder and emergency medical technician levels. By NHTSA's release of the updated federal standards in 2021, there was a significant gap between existing curricula, national standards, and the level of emergency medical care under Wisconsin scope of practice.

The EMS Section, in cooperation with WTCS, revised its curriculum for the EMR, EMT, and AEMT levels in response to the new National EMS Education Standards. Actual revision was conducted by EMS educators drawn across the state from both WTCS and independent training centers. To attempt to minimize the increases content, the curricula included the content of the National EMS Education Standards and additional advanced skills allowed under Wisconsin scope of practice involving medications or invasive procedures. Other lower risk advanced skills were not included to reduce required content. Additionally, the new curricula did not tie content to specific hour requirements but left those decisions to the training centers. Decisions on what to include in curricula were not taken lightly, but involved balancing increases in content with the need to ensure the next generation of EMS personnel have the training necessary to provide Wisconsinites with the emergency medical care they expect from EMS.

For the last two years, changes to EMS scope of practice were minor. At the entry levels of EMR and EMT, changes have largely been restricted to clarifications of skills already in scope of practice or allowing certain existing medications to be administered through alternate routes also within existing scope of practice. Increases in scope of practice have principally been at the paramedic level, where greater depth and breadth in anatomy, physiology, and pharmacology in the existing curriculum allow such expansion without significant impacts to the student. Preventing unintentional scope of practice and training requirement growth remains a focus area for the next state plan period.

Goal: Ensure EMS professionals receive training to meet the care needs and expectations of Wisconsinites while simultaneously preserving entry pathways for new EMS personnel.		
Objective	**Timeline**	**Benchmark**
Ensure curricula for all levels remain in alignment with state and national standards.	3 years	State curricula are reviewed for alignment with the national standards and Wisconsin EMS scope of practice every three years or upon release of a new version of the National EMS Education Standards.
Minimize impact of curricula growth at the levels most impacting volunteer and paid-on-call personnel.	3 years	Limit scope of practice growth at and below the AEMT level to only changes in national scope of practice recommendations or interventions with demonstrated improvement in patient outcome in the pre-hospital setting.

Aid to locals

The EMS Section, with assistance from OPEHC's Grants and Administration Section, annually distributes funds to locals through FAP under Wis. Stat. § 256.12(4) and (5) and the T-CPR Program under Wis. Stat. § 256.35(2m)(d).

FAP is the older and the larger of the programs. Founded under Wis. Act 102 in 1989, FAP has distributed over $100 million to service providers since its creation. FAP consists of two separate types of funds. Support and Improvement funds under Wis. Stat. § 256.12(4) may be used for ambulance service vehicles or vehicle equipment, emergency medical services supplies or equipment, nondurable or disposable medical supplies or equipment, medications, or emergency medical training for personnel. Training and Examination Aid funds under Wis. Stat. § 256.12(5) may be used to purchase training and examinations required for initial certification or renewal of EMR certification and EMT licensure. Details of FAP are provided in Appendix E.

The T-CPR Program distributes funds to public safety answering points (PSAPs) for dispatcher training on T-CPR under Wis. Stat. § 256.35(2m)(d). Dispatchers being able to provide instructions to 911 callers on how to provide CPR assists to minimize delays in time from recognition of sudden cardiac arrest to the time CPR can be initiated. This is a much smaller program, with an annual appropriation of $75,000.

As the last state plan was nearing publication, the EMS Section was working to implement multiple changes to the FAP for SFY 2025. Statutory changes under 2023 Wis. Act 19 allowed non-transporting EMR departments to receive funds directly for the first time in the program's history. The same legislation also allowed all eligible service providers to utilize up to 15% of their Support and Improvement funds to be used for medications and disposable medical supplies. Additionally, the state budget included a more than tenfold increase in the FAP appropriation from $2.2 million to $25 million.

The EMS Board reviewed the FAP distribution formula as required under Wis. Stat. § 256.04(7). The current formula sets aside $1 million of the total appropriation for Training and Examination Aid under Wis. Stat. § 256.12(5), to be divided equally among all services applying for that program. The remaining $24 million was reserved for Support and Improvement funds under Wis. Stat. § 256.12(4). Each service provider is awarded an identical base rate, set by DHS at $10,000, and a per capital amount based on population of its primary service area. Rather than set a fixed per capita rate used from year to year as in previous formulas, the EMS Board recommended the per capita rate be determined each year by dividing the remaining appropriation by the total population reported by all services. This formula increases the proportion of the more versatile Support and Improvement funds over the previous distribution formula, giving service providers greater flexibility to use the funds to address their most pressing local needs.

The EMS Section, in partnership with the OPEHC's Grants and Administration Section, successfully implemented the changes in SFY 2025. This included the redesign of both the application and expense report within the EMS Section E-Licensing system to incorporate the statutory changes and to make completing both processes easier for service providers.

Improving its administration of aids to local government programs continues to be one of the EMS Section's principal goals. The EMS Section transitioned the FAP application and expenditure reporting processes into the E-Licensing system a decade ago. At the time, that transition allowed for better tracking and more efficient recordkeeping than the paper process it replaced. The E-Licensing system, however, was not designed for financial recordkeeping and lacks many basic spreadsheet functions. Awards historically were small enough to still be easily accommodated within the confines of the system. Managing expenditure reporting requirements for increased awards under the new appropriation, however, challenges the limits of the E-Licensing system. The EMS Section, in cooperation with the Grants and Administration Section, is looking into alternative platforms that make offer service providers more financial recordkeeping capabilities. Additionally, the EMS Section remains committed to ensuring that distribution formulas continue to meet the needs of the EMS system.

Goal: Continue to improve administration of FAP.		
Objective	**Timeline**	**Benchmark**
Reduce the complexity of tracking and reporting expenditures at the service level while simultaneously improving program oversight at the state level.	2 years	Expenditure reporting transitioned from E-Licensing to a platform designed for financial management by SFY 2027.
Work collaboratively with partners to ensure the funding distribution formula continues to meet the needs of the EMS system.	2 years	EMS Board reviews the distribution formula within two years with sufficient data to make evidence-based determinations on any changes.

Data

EMS data is a powerful tool in improving EMS and public health in Wisconsin. Service providers are required under Wis. Admin. Code § DHS 110.34(8) to submit a patient care report to DHS through the WARDS within seven days of patient transport. EMR service providers are only required to submit patient care reports to WARDS if advanced skilled were administered while caring for the patient. Beyond serving as the patient care record, these reports can be used by service providers health care partners, and DHS to aid in process improvement work and be analyzed to understand patterns and trends in EMS responses in Wisconsin. The information reported by service providers is determined by DHS. Specific data elements required are typically based on the most current NEMSIS data standard with additional state-created fields. About 900,000 patient care reports are submitted through WARDS annually, making this data a powerful tool to understand and improve EMS performance as well as to inform public health practice.

To inform public health practice as well as to make more information about EMS available to the public, OPEHC produces different reports using patient care report data. In addition to these goals, OPEHC will continue to seek other opportunities to use this data to improve EMS and public health in Wisconsin.

Goal: Continue to build data resources to better understand the EMS system and enable data-driven decision making.		
Objective	**Timeline**	**Benchmark**
Publish WARDS Annual Report.	1 year	Resume publication of WARDS data through an annual report on general EMS response metrics including volume, demographics of patients, and response characteristics and develop procedures for future publications.
Continue routine updates to EMS Personnel Annual Report and EMS Services Annual Report.	1 year	Provide annual standardized reports on EMS personnel and service providers including aggregate information on how many service providers and personnel have specific license levels and endorsements.
Convert Wisconsin EMS and Falls Report to an annual publication.	1 year	Annual publication of the Wisconsin EMS and Falls Report.

Goal: Ensure data quality by maintaining alignment with applicable national data standards.		
Objective	**Timeline**	**Benchmark**
Review WARDS validation rules and make updates based on feedback and state needs.	1 year	Updated validation rules will have a change log, summary, and be communicated out to EMS providers and partners.
Migrate WARDS to the NEMSIS v. 3.5.1 standard.	1 year	EMS providers can successfully submit v. 3.5.1 data to WARDS.

Public health preparedness and health care system integration

OPEHC facilitates integration of ambulance service providers and hospitals in the same geographic area under Wis. Stat. § 256.08(4)(f) and coordinates EMS-related preparedness and emergency activities with the Department of Military Affairs under Wis. Stat. § 256.08(4)(i). OPEHC's structure of combining EMS, trauma, and public health preparedness facilitate EMS involvement into the larger health care and preparedness systems as OPEHC already has staff devoted to all these functions.

The EMS Section worked with partners within and outside OPEHC to revise three publications to prove service providers and EMS professionals with better resources when operating with other health care partners and for larger incidents. These included the EMS Communications Plan, the EMS Mass Casualty Incident Planning Guide, and the Helicopter EMS Utilization Guidelines.

The EMS system's twin roles of responding to medical emergencies and transporting patients – whether moving patients from emergency scenes to the hospital or moving patients between health care facilities – is critical to the success of state's hospital, trauma and emergency preparedness systems for both routine needs and during large-scale events. Additionally, community EMS programs offer new areas of possible collaboration in injury prevention, rural health care, and public health. Continued coordination between EMS and other health care and preparedness partners therefore enhances the capacity across all systems to increase the health and safety of Wisconsinites.

Goal: Foster and expand existing partnerships integrating EMS into the greater health care and emergency preparedness systems.		
Objective	**Timeline**	**Benchmark**
Integrate prehospital data collection with trauma registry data to support continuum of care analyses.	4 years	Aligned indicators from Wisconsin Ambulance Run Data System (WARDS) and the trauma registry focused on system analysis. Indicators are recorded in an evaluation matrix and recorded annually. Integrated evaluations are shared at STAC and EMS Board meetings annually.
Improve coordination between leading trauma and EMS bodies.	2 years	At least 1 EMS Board representative at each STAC meeting. At least 1 STAC representative at each EMS Board meeting.
Review and maintain EMS-focused preparedness resources on a standardized schedule.	4 years	Ensure the EMS Communications Plan and the EMS Mass Casualty Incident Response Planning Guide are reviewed at least once every five years to ensure information remains current.

Glossary

911: A three-digit emergency telephone number accepted and promulgated by the telephone industry as the nationwide emergency number.

911 non-transporting: A type of service where an emergency medical services provider responds to 911 calls for service and provides care but is not licensed to provide ambulance transportation.

911 transporting: A type of service where an emergency medical services provider is licensed to respond to 911 calls for service, provides emergency medical care, and provide ambulance transportation.

Advanced life support (ALS): Pre-hospital and interfacility emergency medical care consisting of basic life support procedures and invasive lifesaving procedures including the placement of advanced airway adjuncts, intravenous infusions, manual defibrillation, electrocardiogram interpretation, administration of approved drugs and other advanced skills identified in the Wisconsin scope of practice.

Ambulance: An emergency vehicle, including any motor vehicle, boat, or aircraft, whether privately or publicly owned, which is designed, constructed, or equipped to transport sick, disabled, or injured individuals.

Ambulance service provider: An emergency medical service provider engaged in the business of transporting sick, disabled or injured individuals by ambulance to or from facilities or institutions proving health services.

Basic life support (BLS): Emergency medical care that is rendered to a sick, disabled, or injured individual, based on signs, symptoms, or complaints, prior to the individual's hospitalization or while transporting the individual between health care facilities and that is limited to use of the knowledge, skills, and techniques received from training for licensure as an emergency medical technician, or for certification as an emergency medical responder.

Cardiopulmonary resuscitation (CPR): An emergency procedure that combines chest compression, with artificial ventilation, to manually preserve brain function and profusion.

Career: A system of staffing in which a service provider uses personnel who are paid a regular wage for all time while on shift, whether actively engaged in EMS responses or while awaiting a call. Career personnel may include both full-time and part-time time personnel.

Combination: A system of staffing in which a service provider uses a mix of two or more staffing types (career, paid-on-call, or volunteer).

Community emergency medical services (CEMS): Use of emergency medical services practitioners in non-traditional and non-emergency settings to connect patients with other health care resources or assist in bridging other gaps within the health care system.

Credential: Written authorization by the service director and medical director of a licensed emergency medical services provider permitting a certified emergency medical responder or licensed emergency medical services practitioner to perform specified emergency medical care while in the service of the provider. To be credentialed means to hold a credential issued by a licensed emergency medical services provider.

E-Licensing: A web-based licensing management system administered by DHS allowing individuals and service providers to view current certificate and license status and apply for permits, certificates, and licenses.

Emergency medical care: Medical care to sick, disabled, or injured individuals at the scene of an emergency, during transport to a hospital, while in the hospital emergency department until responsibility for care is assumed by the regular hospital staff, and during transfer of a patient between health care facilities.

Emergency medical responder (EMR): A person certified to provides emergency medical care to a sick, disabled, or injured individual prior to the arrival of an ambulance; may also be used as a secondary ambulance crew member for ambulance service providers meeting population requirements in Wis. Stat. §§ 256.15(4)(e) and (f).

Emergency medical service (EMS): An arrangement of personnel, communications, equipment, and supplies for the delivery of emergency medical care.

Emergency medical services practitioner (EMS practitioner): An individual licensed as an EMT, AEMT, intermediate, or paramedic.

Emergency medical services provider: An entity licensed to provide emergency medical services at any license level, whether transporting or non-transporting.

Emergency medical technician (EMT): An individual who is licensed by the Department of Health Services to administer basic life support and to properly handle and transport sick, disabled or injured individuals.

Intercept: The transfer of care of a patient between an ambulance and an air medical provider or ALS provider that can provide a higher level of medical care.

Interfacility: The transfer of a patient between two health care facilities by an ambulance service provider.

Non-volunteer: A career system of staffing.

Paid-on-call: A system of staffing in which a service provider uses personnel who are activated and compensated for EMS responses but receive no or only minimal compensation while available for response.

Primary service area: The geographical area in which an ambulance service provider is designated to provide first-in emergency medical services under contract with a local government. Primary service area does not include areas that the provider serves through mutual aid or back-up arrangement.

Public Safety Answering Point or Public Safety Access Point (PSAP): A 911 call center responsible for receiving calls from the public for emergency assistance from law enforcement, fire, or emergency medical help.

Region: One of seven groups of contiguous counties used by the EMS Section for administratively dividing Wisconsin. EMS region boundaries align with those of the Health Care Emergency Readiness Coalitions and Regional Trauma Advisory Councils.

Regional EMS system: An emergency medical services area (trade, catchment, market, patient flow, geographic, or governmental) that provides essentially all the definitive emergency medical care for all emergencies and for the most critically ill and injured patients within the area.

Tactical emergency medical services (TEMS): Emergency medical services provided by licensed emergency medical services practitioners operating as part of a law enforcement tactical team.

Telecommunicator CPR (T-CPR): A program where 911 call takers, dispatchers, or telecommunicators are trained to provide instructions over the telephone to 911 callers on performing CPR when a patient is in cardiac arrest.

Volunteer: A system of staffing in which a service provider uses only personnel who receive no monetary compensation for any EMS activities.

Wisconsin Ambulance Run Data System (WARDS): A web-based reporting system emergency medical service providers use to enter to use to enter and submit patient care data via the internet.

Appendix A—EMS personnel data

The exact number of certified and licensed personnel fluctuates almost daily. New individuals are constantly entering the EMS system through initial education in Wisconsin or reciprocity from other states. Data on certified and licensed personnel therefore represents a snapshot of the system at that time. The E-Licensing system does not have ability to pull data retroactively. The EMS Section therefore cannot retroactively pull data for specific dates or times. The information contained within this appendix shows the EMS personnel data for July 1, 2025. That date is exactly two years from the start of the current triennial certification and licensure period. Overall numbers of personnel are therefore at the higher end of the cycle. Note that overall numbers may not add up to the total number of certified and licensed personnel elsewhere in this plan as some individuals may not have reported information for all fields.

Sex

EMS professionals skew more male than the general population. The prevalence of males is not without precedent given the overlap between EMS and fire personnel, as firefighting as a field skews more heavily male than the general population. While this trend is common across certification and license levels, males constitute an even larger percentage of EMS personnel at the intermediate and paramedic levels.

Figure A1. EMS professionals by sex on July 1, 2025

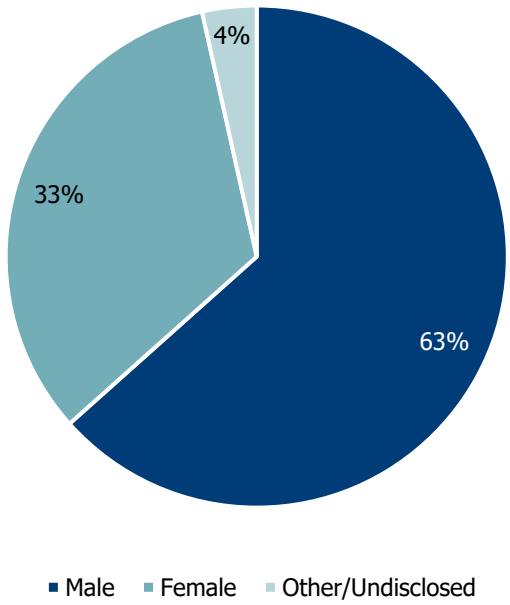


Figure A2. Certification and license levels by sex on July 1, 2025

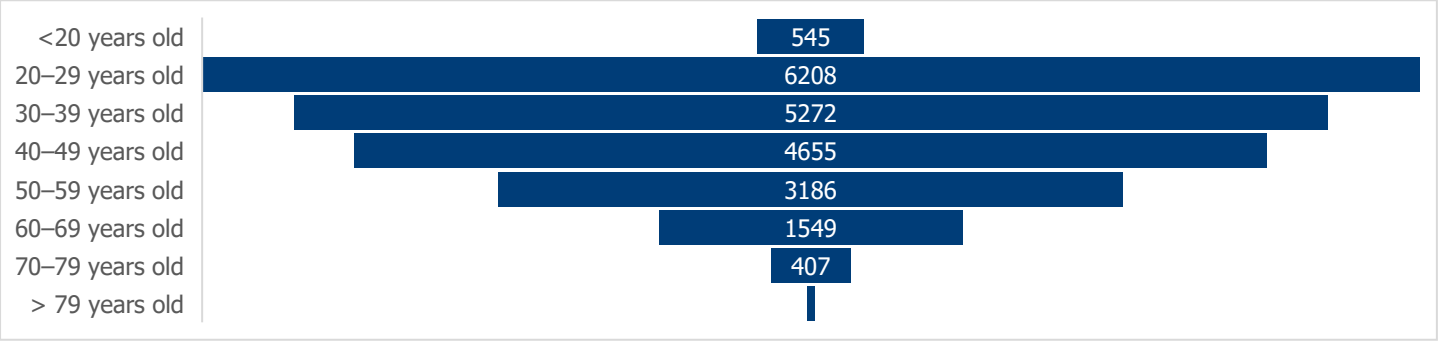
Level	Percent Male	Percent Female	Percent Undisclosed
EMR	62.22%	35.10%	2.68%
EMT	59.33%	36.17%	4.50%
AEMT	50.50%	44.94%	4.56%
Intermediate	78.26%	17.39%	4.35%
Paramedic	74.79%	23.15%	2.06%
Total	**63.38%**	**33.12%**	**3.50%**

Age

Certified and licensed personnel span a wide age range from the statutory minimum of age 18 to individuals in their late 80s. Individuals under age 30 constitute the largest demographic group, with slowly diminishing numbers for each age group thereafter. Average age is highest among intermediates as initial training for that level has not been offered for that level in a decade. Average age was lowest for the entry level of EMT. The level most associated with career personnel, paramedic, also as skews younger with a lower percentage of its members over the age of 60 than other levels. Levels more commonly associated with volunteer and paid-on-call personnel such as

EMR and AEMT tended to have higher percentages of individuals over 60. Additionally, older age groups were much more likely to be male than those under 30.

Figure A3. Age distribution of EMS personnel on July 1, 2025



Note: The total number of individuals will not match previously identified totals for July 1, 2025, because age data was not available for all individuals.

Figure A4. Average age and age range by certification and license level on July 1, 2025

Level	Average Age	Age Range
EMR	44	18-87
EMT	36	18-89
AEMT	45	19-85
Intermediate	54	39-73
Paramedic	39	18-81
All Levels	**39**	**18-89**

Figure A5. Age breakdown of certification and license levels on July 1, 2025

Level	<20	20–29	30–39	40–49	50–59	60–69	70–79	>79
EMR	2.40%	15.61%	21.87%	23.54%	19.77%	12.27%	4.19%	0.34%
EMT	4.49%	39.27%	19.85%	17.29%	12.10%	5.38%	1.41%	0.21%
AEMT	0.10%	16.18%	21.44%	25.10%	19.49%	13.98%	3.51%	0.25%
Intermediate	0.00%	0.00%	4.35%	23.91%	47.83%	21.74%	2.17%	0.00%
Paramedic	0.13%	23.16%	33.45%	25.08%	13.42%	4.17%	0.57%	0.02%
Total	**2.50%**	**28.40%**	**24.11%**	**21.29%**	**14.57%**	**7.08%**	**1.86%**	**0.18%**

Figure A6. Figure Age breakdown by sex on July 1, 2025

Gender	<20	20–29	30–39	40–49	50–59	60–69	70–79	>79
Male	49.72%	56.11%	67.01%	67.69%	69.33%	60.62%	68.55%	70.00%
Female	45.14%	40.01%	30.77%	29.32%	27.59%	34.54%	27.52%	25.00%
Undisclosed	5.14%	3.88%	2.22%	2.99%	3.08%	4.84%	3.93%	5.00%

Participation

The rate that certified and licensed individuals participate within the EMS system, as measured by the percentage of individuals with at least one credential with a service provider, is not uniform across the system. Individuals under the age of 30 also participate at lower rates, with teenagers being the

least likely age group to hold a credential with a service provider. Males are much more likely than females to participate up to age 50, after which the gap narrows significantly. EMTs participate at a much lower rate than individuals at other levels. Even within levels participation can vary significantly among age groups. EMRs and EMTs, for example, have rather low participation among the youngest age groups but relatively high participation among older age groups. Paramedic participation is consistently high among younger groups until dropping off somewhat for individuals over 50. AEMT and intermediate participation, however, remains relatively consistent level across age levels.

Figure A7. Percentage of individuals credentialed with service providers by level on July 1, 2025

Level	Percent Credentialed with Service Provider	Percent not Credentialed with Service Provider
EMR	84.0%	16.0%
EMT	70.8%	29.2%
AEMT	83.8%	16.2%
Intermediate	89.1%	10.2%
Paramedic	85.5%	14.5%
All Personnel	**78.4%**	**21.6%**

Figure A8. Percentage of individuals credentialed with service providers by age on July 1, 2025

Level	<20	20–29	30–39	40–49	50–59	60–69	70–79	>79
EMR	44.1%	77.6%	85.0%	86.7%	84.4%	89.7%	91.3%	92.3%
EMT	59.3%	61.8%	73.5%	83.2%	76.9%	77.4%	85.6%	90.5%
AEMT	100%	83.2%	81.1%	84.8%	87.4%	82.9%	81.4%	40.0%
Intermediate	N/A	N/A	100%	81.8%	86.4%	100%	100%	N/A
Paramedic	87.5%	88.3%	86.8%	86.8%	77.8%	77.6%	71.4%	0.0%
All levels	**57.1%**	**70.4%**	**81.1%**	**85.2%**	**80.3%**	**82.4%**	**86.0%**	**82.5%**

Due to the limited number of intermediates and new initial intermediate courses no longer being offered, there are no intermediates in several age groups. These age groups are marked as N/A to distinguish them from age groups where personnel exist but none in that age group were credentialed with a service provider.

Figure A9. Percentage of individuals credentialed with service providers by sex on July 1, 2025

Level	<20	20–29	30–39	40–49	50–59	60–69	70–79	>79
Male	63.1%	74.8%	83.8%	91.5%	80.6%	81.5%	85.7%	85.7%
Female	53.7%	65.8%	75.8%	78.1%	79.3%	83.2%	85.7%	80.0%
Undisclosed	32.1%	55.2%	74.4%	85.6%	82.7%	88.0%	93.8%	50.0%
Overall	**57.1%**	**70.4%**	**81.1%**	**85.2%**	**80.3%**	**82.4%**	**86.0%**	**82.5%**

Appendix B—Service provider data

As with individuals, data on licensed service providers represents a snapshot of the system at that time. The E-Licensing system generally does not have ability to pull data retroactively. The EMS Section therefore cannot retroactively pull data for specific dates or times. The information contained within this appendix shows service provider data for July 1, 2025. That date is exactly two years from the start of the current triennial certification and licensure period. Unlike individuals, however, service provider numbers are generally not subject to wide fluctuations during the licensing period.

License level

Among service providers, EMR and paramedic are the two most common license levels. Intermediate service providers are the least common, as initial training courses for that level have not been available for over a decade.

Use of different license levels varies widely within the EMS system. The overwhelming majority of 911 non-transporting service providers are licensed at the EMR level. Among 911 transporting service providers, the EMT, AEMT, and paramedic levels are all well represented. Paramedic licensure predominates among interfacility, TEMS, CEMS, and air medical service providers.

Figure B1. Serice provider license levels on July 1, 2025

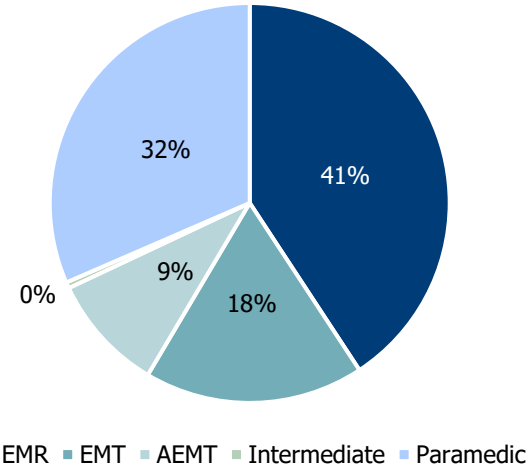
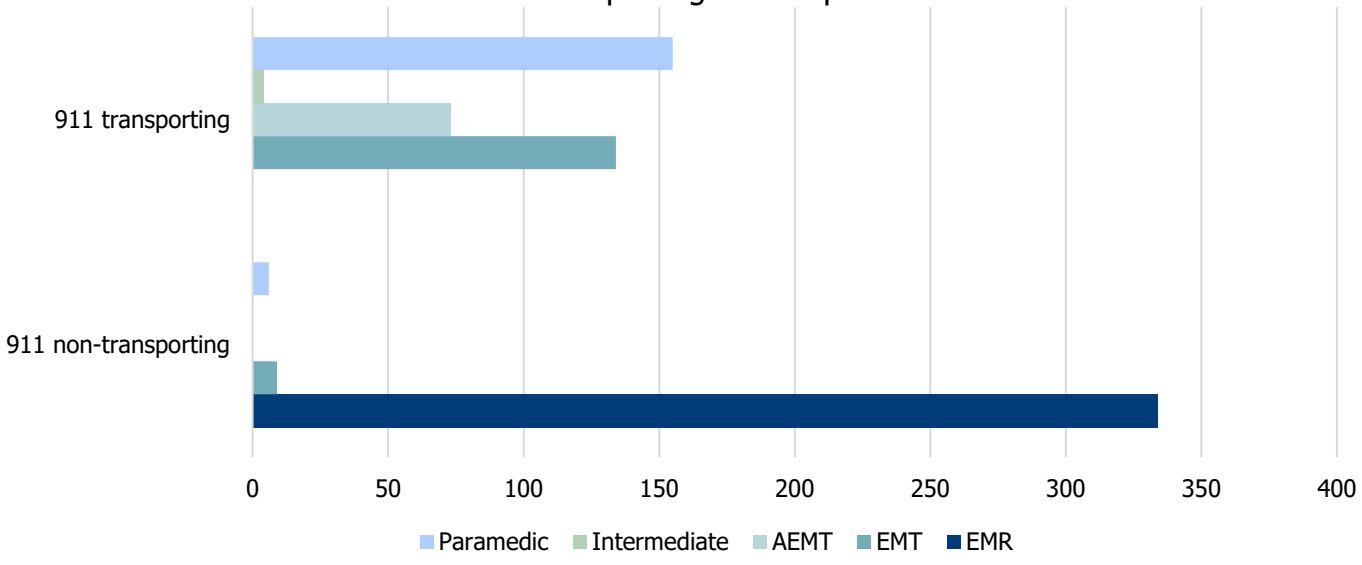


Figure B2. Comparison of license levels between 911 transporting and 911 non-transporting service providers

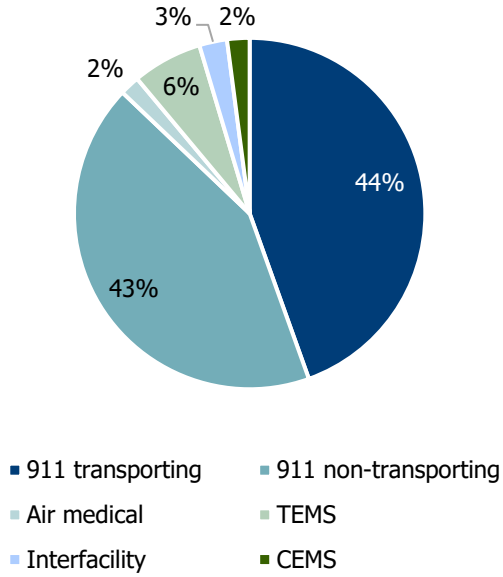


Primary type of service

Primary service type refers to the principal activity for which a service provider is licensed. Types of service include 911 transporting, 911 non-transporting, interfacility, air medical, interfacility (including ground critical care), TEMS, and CEMS.

If service providers have a designated primary service area or other 911 responsibility, then that defaults to their primary service type within the E-Licensing system. Over 85% of EMS service providers identify some form of 911 response as their primary service type. 911 transporting and 911 non-transporting are the two most common primary service types, with each comprising a similar overall proportion of the EMS system.

Figure B3. Service provider primary service type on July 1, 2025



The more specialized interfacility, air medical, CEMS, and TEMS communities all constitute significantly smaller portions of the EMS system.

Organizational type

Organization type refers to the ownership or operational structure of the service provider. Organizational types include fire department, government (excluding fire departments), hospital, private entity (other than hospitals), and Tribal.

Among service providers with 911 responsibilities, fire department-based EMS is the single largest organizational type. Fire-based EMS is relatively more common among 911 non-transporting service providers than among 911 transporting service providers.

Figure B4. Service provider organizational types on July 1, 2025

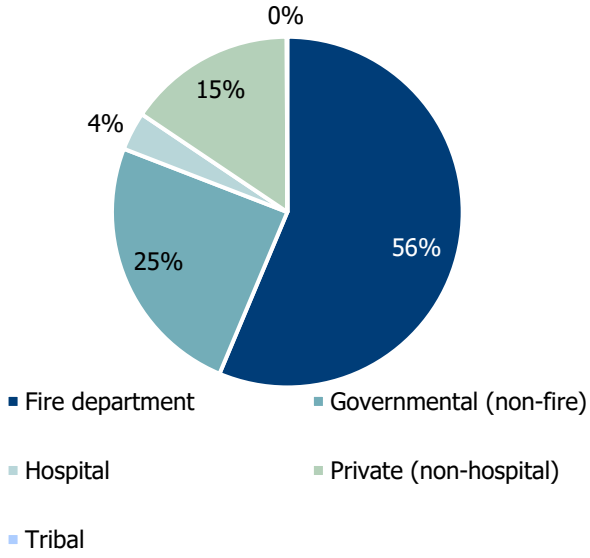
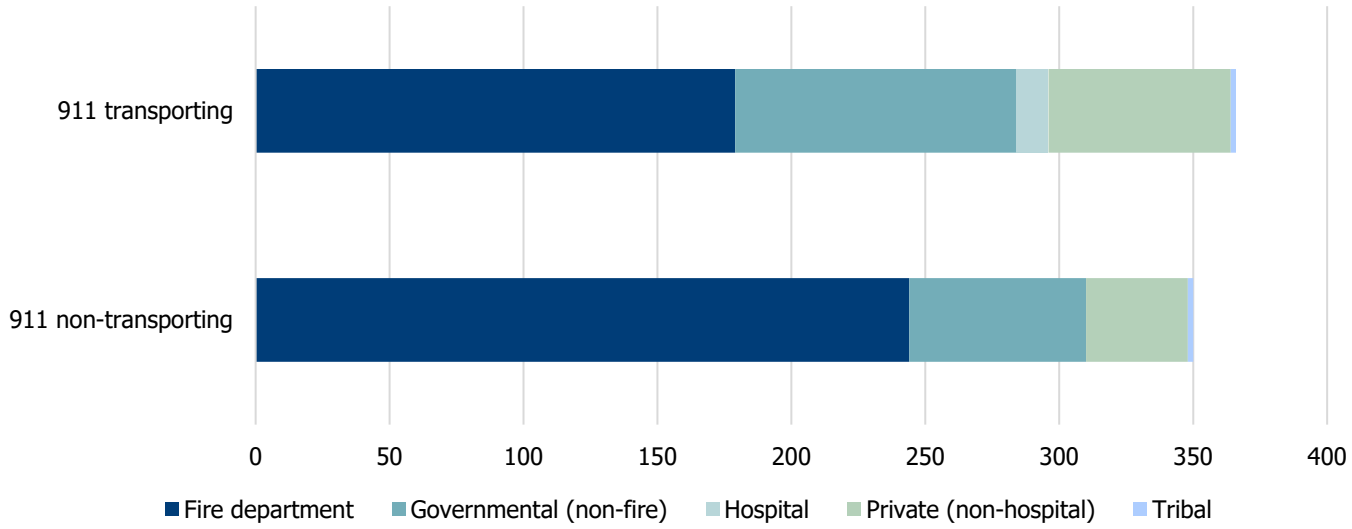


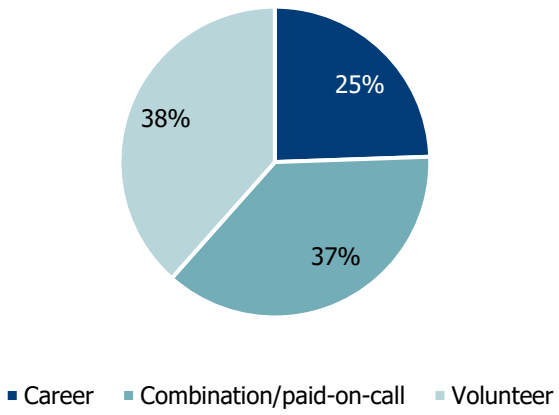
Figure B5. Comparison of organizational types between 911 transporting and 911 non-transporting providers



Organizational status

Service organizational status refers to the way service providers compensate their members. Among all service providers, service organizational status is relatively evenly split between combination/paid-on-call (37.1%) and volunteer (38.4%). Career service providers constitute a slightly smaller group (24.5%).

Figure B6. Service provider organizational statuses on July 1, 2025

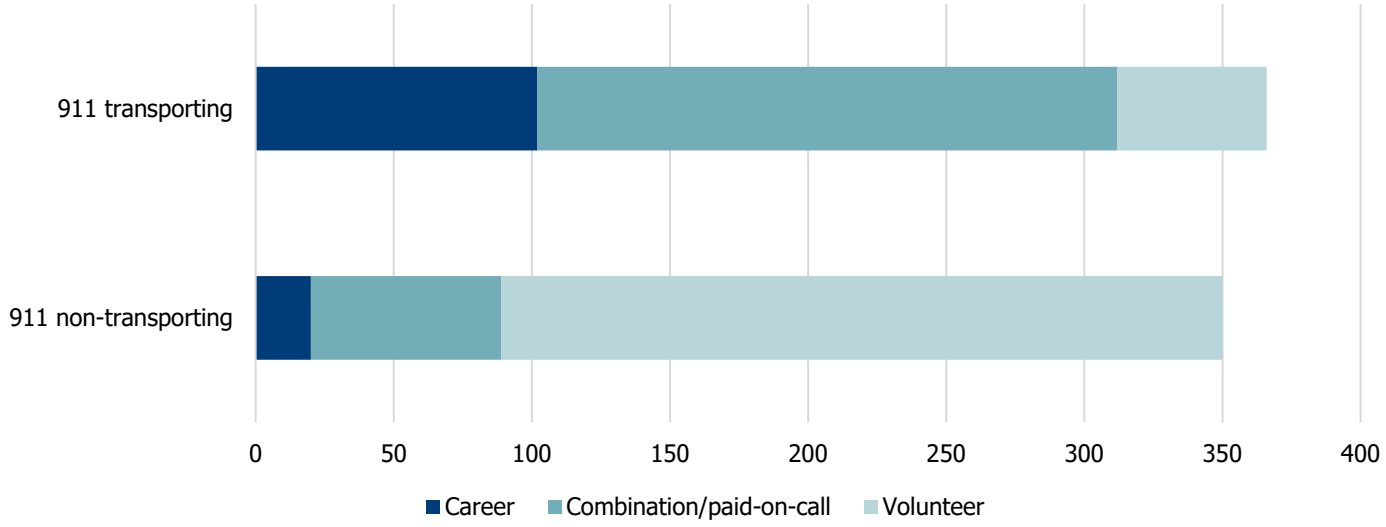


Differences between service types are, however, quite pronounced. Among 911 transporting service providers, volunteer service providers comprise a much lower proportion than among service providers overall. The opposite is true among 911 non-transporting service providers where career and combination/paid-on-call are less common while volunteer predominate. Interfacility, air medical, CEMS, and TEMS service providers are much more likely to be career than either volunteer or combination/paid on call.

Combination and paid-on-call is a mixture of two separate staffing models. Paid-on-call service providers pay their members when activated but generally do not pay or give only a small stipend for time while waiting for calls. Combination service providers use a mixture of at least two of the other staffing models. Depending on the mix, a combination department could function much more like a career, a paid-on-call, or a volunteer department. For example, a service provider with only a paid

director may look more like a volunteer service provider. Conversely, a service provider where most staff are career but paid-on-call personnel supplement staff may function more like a career provider.

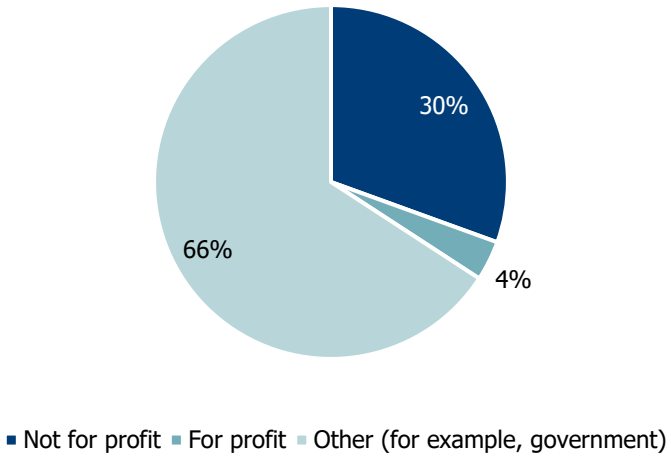
Figure B7. Comparison of organizational status between 911 transporting and 911 non-transporting providers



Organizational tax status

Organizational tax status refers to whether a service operates for profit, not for profit, or as part of a government body. Most licensed service providers are operated by a governmental entity, whether that be a municipality, a county, or a district.

Figure B8. Service provider organizational tax statuses on July 1, 2025



Appendix C—911 data

While overall service provider licensing numbers give some idea of the EMS system, they do not always provide the best picture of how the EMS system is distributed across Wisconsin. The total number of service providers by license level, type, or pay status do not correspond to the breakdown of 911 service across the state. In practice, 911 emergency response is a complex patchwork of hundreds of ambulance service providers and non-transporting service providers.

Local decision makers determine what is best type of EMS for their communities from among the options allowed under statute and administrative rule. This results in an uneven distribution of license levels, organizational types, and organizational statuses. As a home rule state, such differences are both expected and entirely appropriate. There is not a single right license level, organizational type, or organizational status. Likewise, none of the means of providing EMS is inferior to another, so long as it works for the communities it services.

The data below represents a picture of the 911 response system in 2024 as viewed from the size of populations protected by different levels and types of services. Note, as populations are not evenly distributed and ambulance coverage by area information is not available to the EMS Section, the EMS Section could not attempt a similar review of ambulance coverage by geographic area. As this information is from 2024, overall composition of service providers will be similar to, but not completely align with the July 1, 2025, numbers used elsewhere in this plan. Additionally, this information is not readily trackable or reportable through the E-Licensing system. 911 coverage data cannot therefore be produced on demand.

State demographics

Wisconsin is a diverse state with communities that range in population from sparsely populations rural towns with less than 100 people to the densely populated Milwaukee metropolitan area. Population density tends to be higher in southeastern Wisconsin, the Madison metropolitan area, and the Fox Valley.

Wisconsin is subdivided into 72 counties, which in turn are further divided into cities, villages, and towns.

For administrative purposes, the EMS Section divides the state into seven regions. These regions are the same as those OPEHC uses for its trauma and Health Care Emergency Readiness Coalitions. There are large differences in both area and population among the regions.

Figure C1. EMS Regions Map

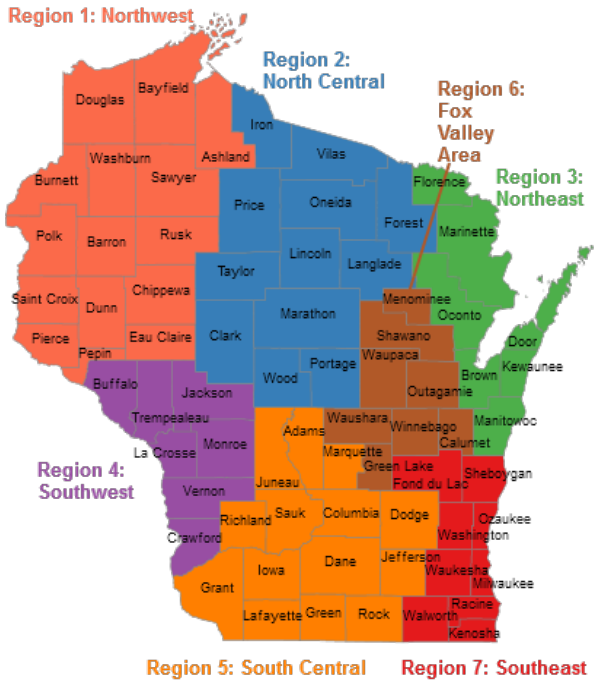


Figure C2. Municipalities in 2024

Municipality Type	Number	Population [2]
City	190	3,320,998
Town	1242	1,579,679
Village	417	1,088,573
Total	**1849**	**5,989,250**

Figure C3. EMS Regions in 2024

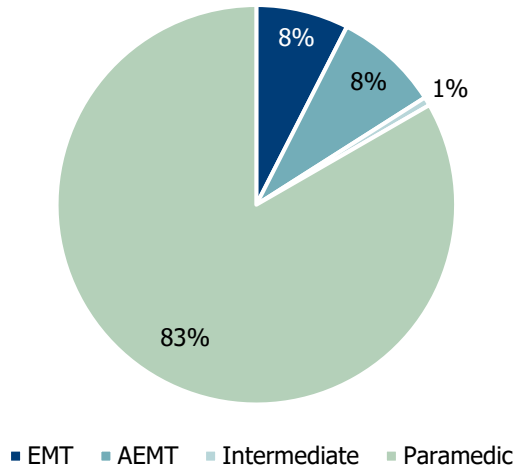
Region	Number of counties	Population [3]
Region 1 – Northwest	15	607,861
Region 2 – Northcentral	12	479,077
Region 3 – Northeast	7	494,301
Region 4 – Southwest	7	282,313
Region 5 – Southcentral	14	1,276,169
Region 6 – Fox Valley	8	563,932
Region 7 – Southeast	9	2,285,597
Total state population	**72**	**5,989,250**

Ambulance service providers

While not required of all municipalities as an essential service, all municipalities in Wisconsin had ambulance protection in the period. Note that counties, cities, villages, and towns, not DHS, ultimately determine which ambulance service provider to use.

This section will look at provision of ambulance service through four perspectives: license level, organizational type, organizational status, and organizational tax status. Results for each of these fields are independent of one another even when trends for multiple fields are referenced together.

Figure C4. Percentage of state population served by ambulance service license level



As looked at by the whole state, a large majority of the state's population reside in municipalities protected by ambulance service providers licensed at the paramedic level. Note that this only includes ambulance service providers licensed at the paramedic level. It does not take into account any lower-level rural ambulance service providers that may provide care based on the highest member on board under Wis. Stat. § 256.15(4m).

[2] Department of Administration. (2024). Demographic Services Center's 2024 Population Estimates: Wisconsin's Population Increases Modestly. State of Wisconsin. https://doa.wi.gov/DIR/Final_Ests_Summary_2024.pdf
[3] Department of Administration. (2024). Demographic Services Center's 2024 Population Estimates: Wisconsin's Population Increases Modestly. State of Wisconsin. https://doa.wi.gov/DIR/Final_Ests_Summary_2024.pdf

Smaller, but still sizable, majorities receive their ambulance service from fire department-based service providers and from service providers using career staff.

Figure C5. Percentage of state population serviced by ambulance service organization type

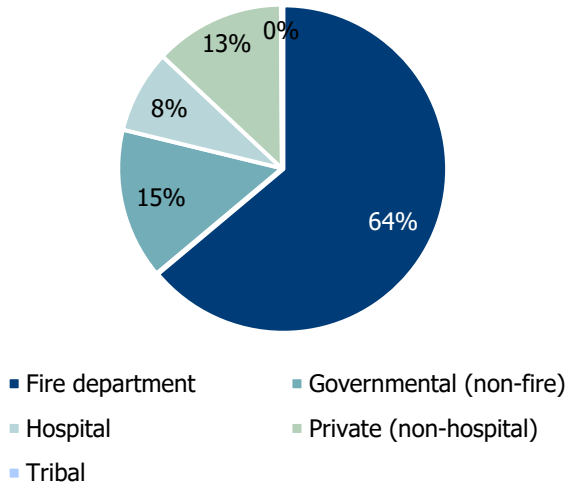
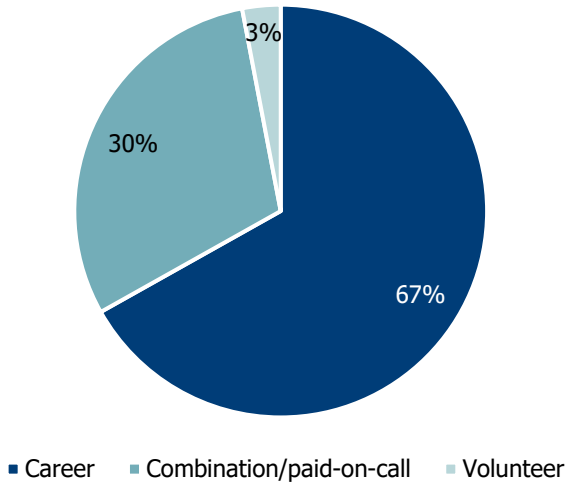
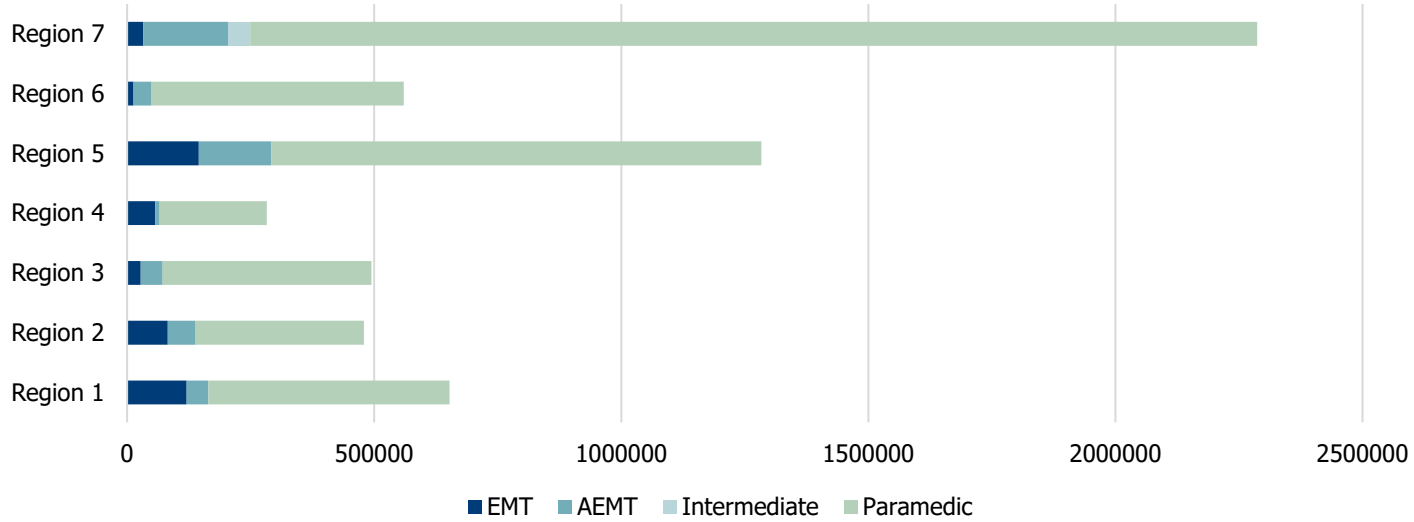


Figure C6. Percentage of state population served by ambulance service organizational status



All seven regions had large majorities of their populations protected by paramedic level ambulance service providers. Outside of the dominance of the paramedic level, relative prevalence of other license levels varied by region.

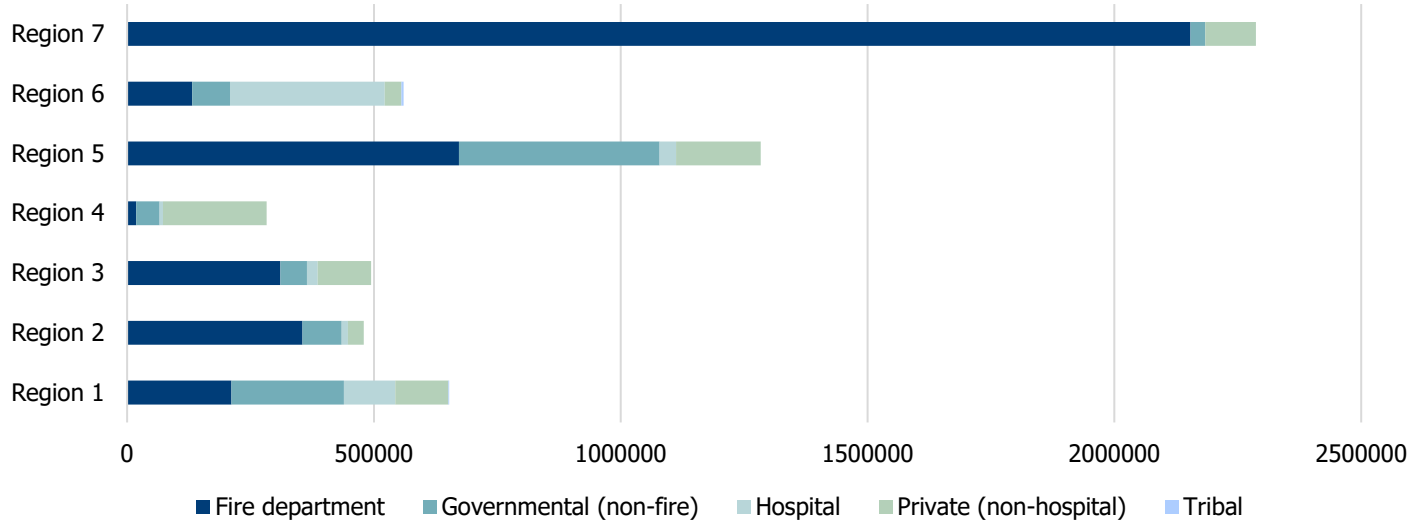
Figure C7. Regional breakdown of people protected by ambulance service license level



There was considerably more variation by organizational type. While fire department-based ambulance service constituted a statewide majority, it was a majority in just four of the regions.

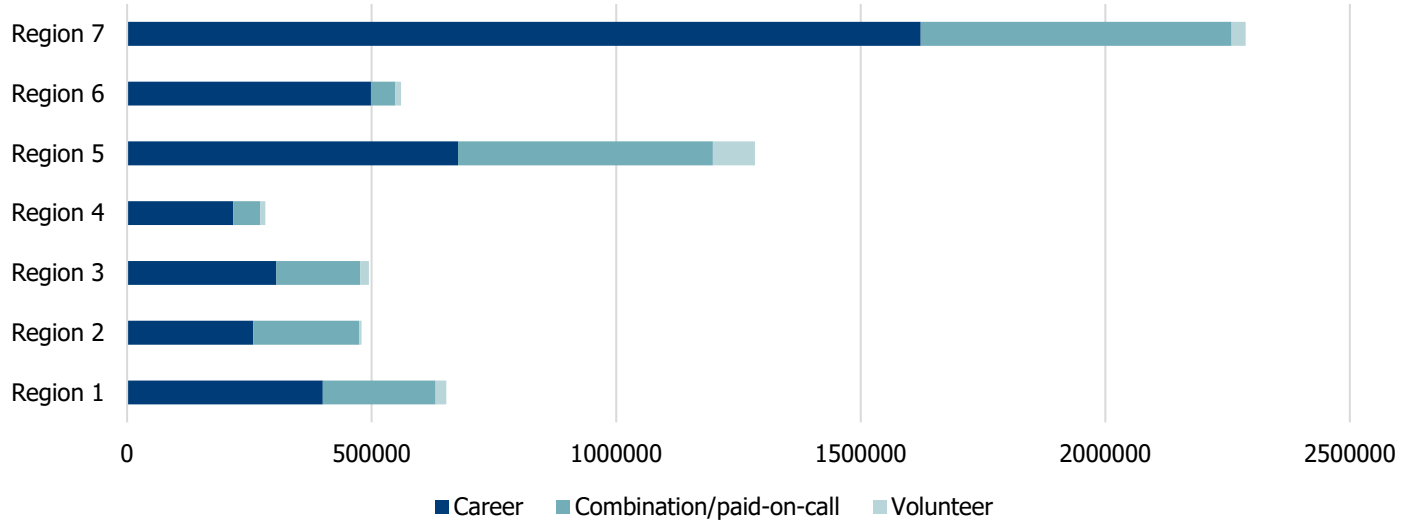
Regions where large, regional EMS systems are more common (for example, Regions 4 and 6), tended to have a lower population protected by fire department-based ambulance service.

Figure C8. Regional breakdown of people serviced by ambulance service organizational type



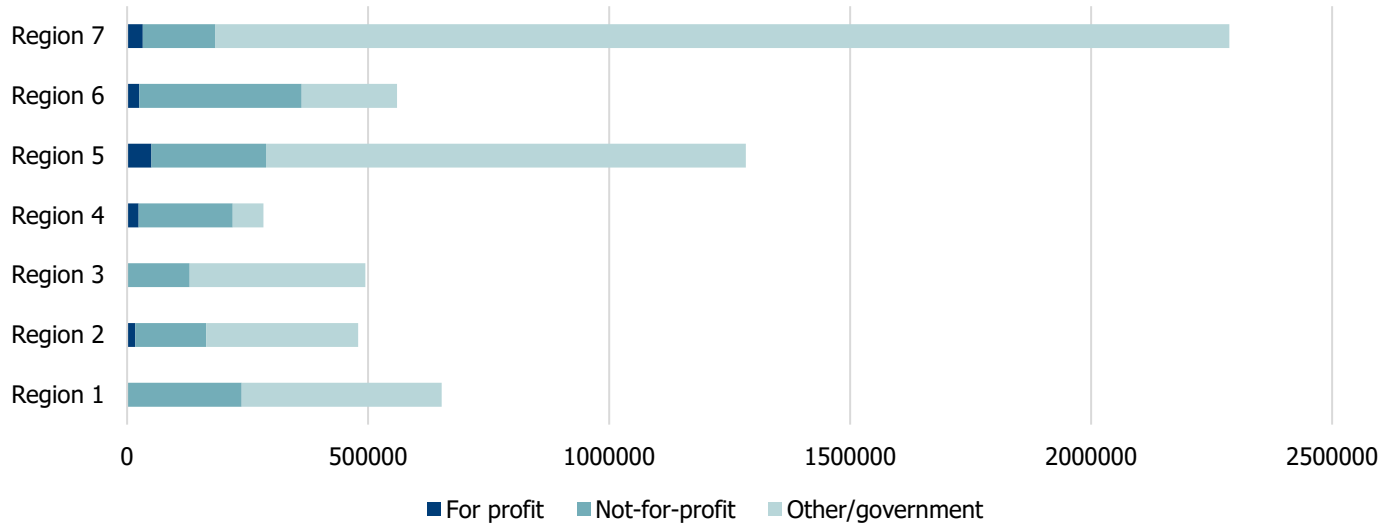
A majority of the population was protected by career ambulance service providers in all of the regions, but the size of that majority varied significantly. The regions with large, regional EMS systems also tended to have higher percentages of populations protected by career staff.

Figure C9. Regional breakdown of people protected by ambulance service organizational status



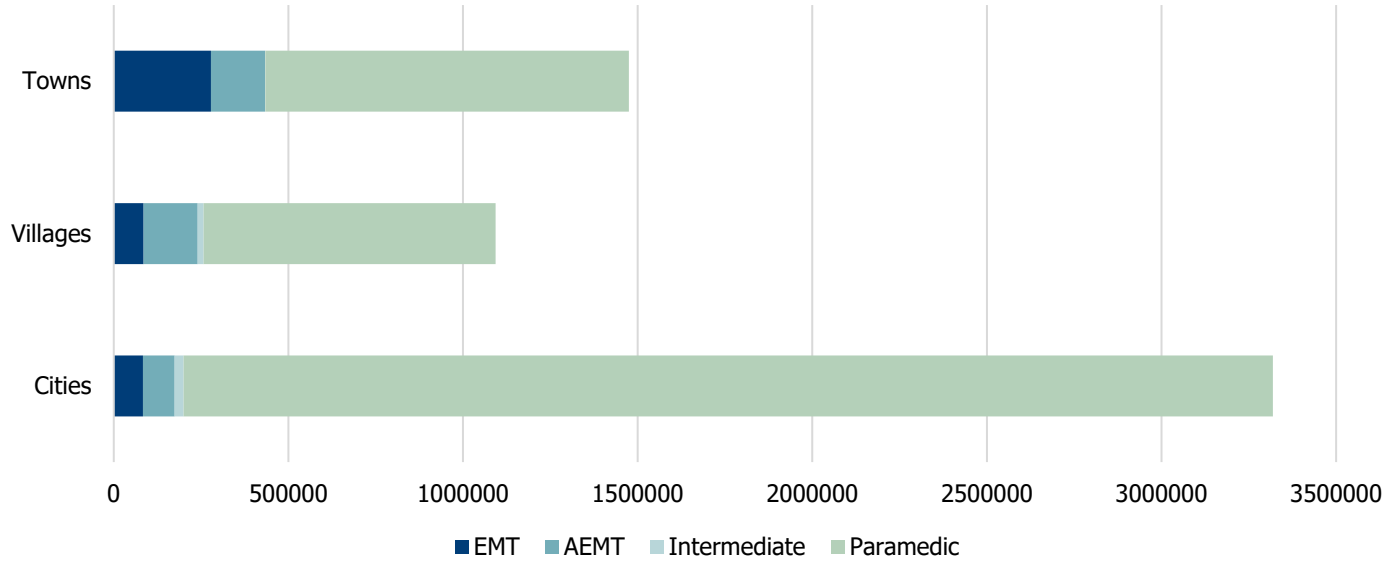
Government-owned EMS predominates in all but the two regions where large, regional EMS systems are common.

Figure C10. Regional breakdown of people protected by ambulance service organizational tax status



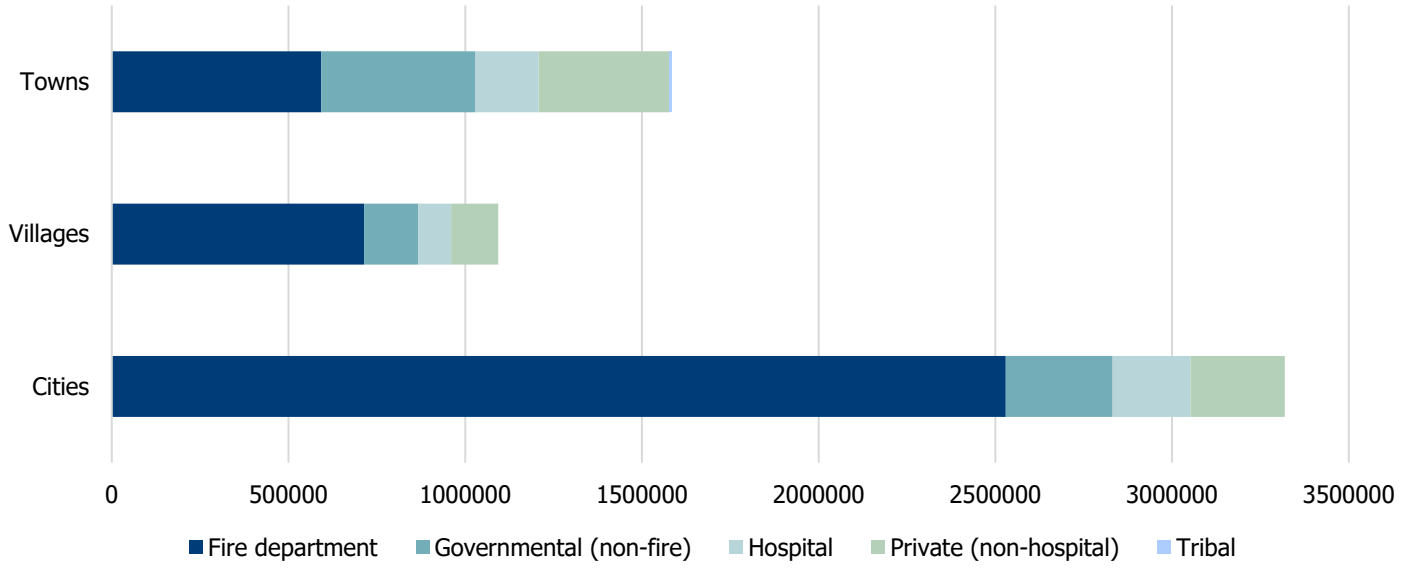
While the paramedic level service was dominant by population across all three municipality types, EMT and AEMT were relatively more common among towns and villages than in cities.

Figure C11. Muncipality breakdown of ambulance service license level



Fire department-based ambulance service protects large majorities of the population in cities and villages. Towns are significantly more varied in how their ambulance service is provided.

Figure C12. Munipality breakdown of ambulance service organizational type



When looking at the service organization status, there was a pronounced split between cities and the other municipality types. A large majority of the population receives ambulance service from a career service provider in cities. Not surprisingly, the split between career and combination/paid-on-call service providers was closer in villages and towns. Also not surprisingly, towns have both the greatest actual number and the highest proportion of population served by volunteer service providers.

Figure C13. Municipality breakdown of ambulance service organizational status

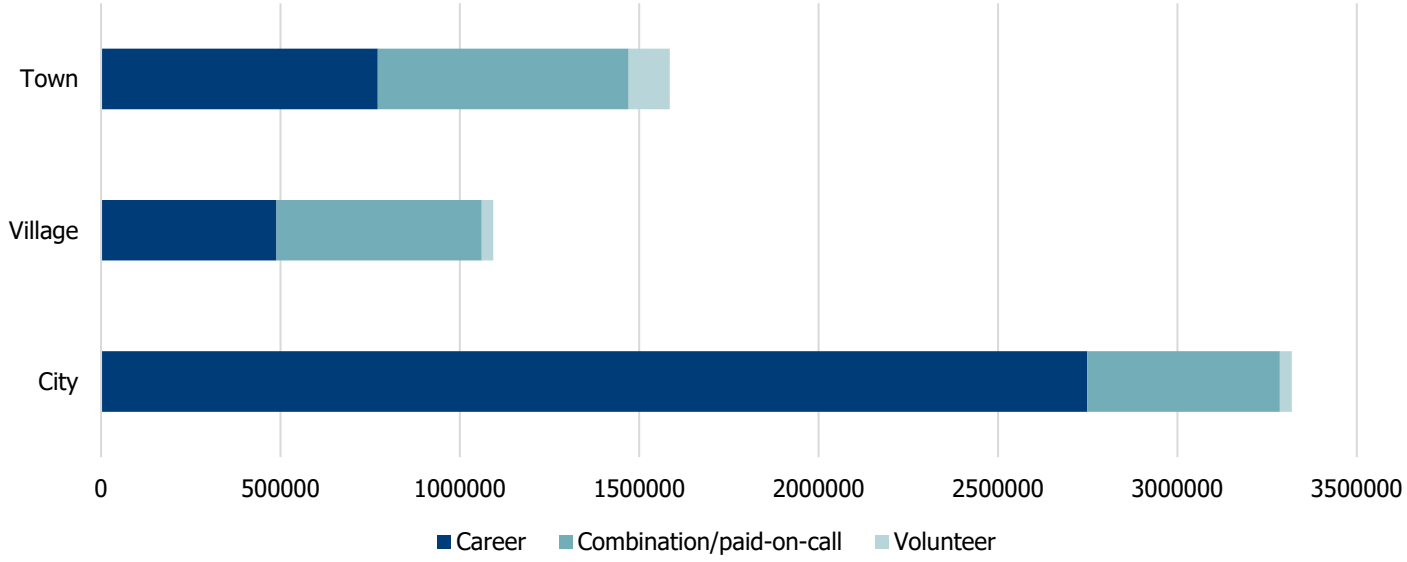
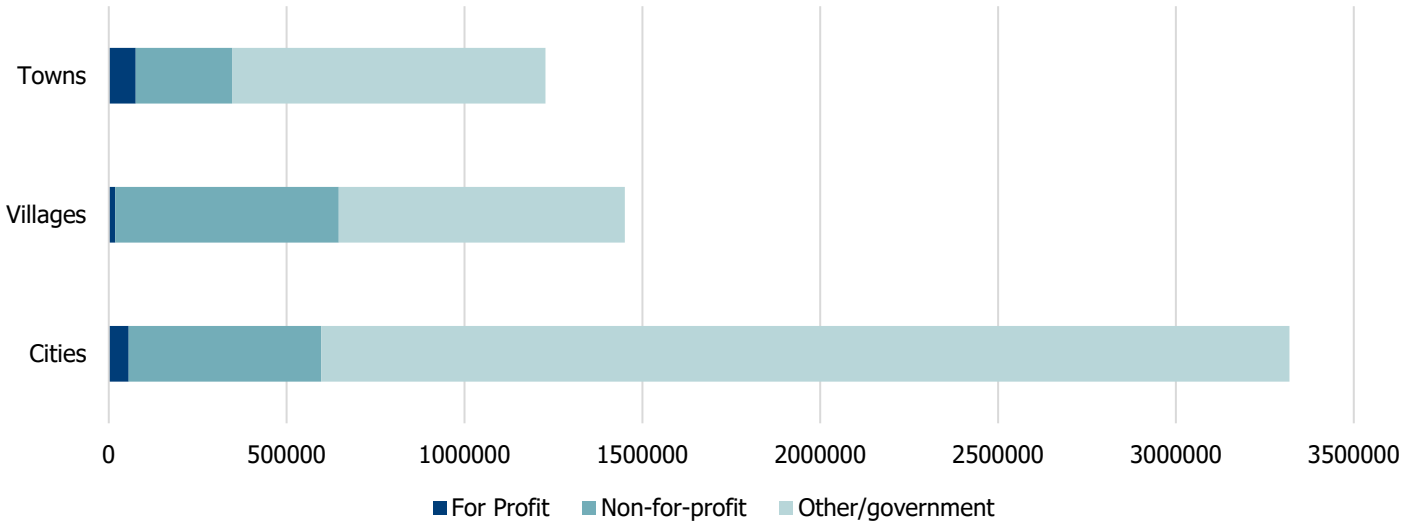


Figure C14. Municipality breakdown of ambulance service organizational tax status



Although the EMS Section does not have access to information on ambulance protection by geographic area, overall numbers of municipalities protected by each of the organizational status suggest there would be differences over the population figures. The overall number of cities receiving ambulance protection from career service providers was a much narrower majority than the overall population protected by career personnel in cities. The number of cities and villages protected by volunteer ambulance service was also much higher than the percentage of city and village populations protected by volunteer ambulance service.

Figure C15. Ambulance organizational status in cities

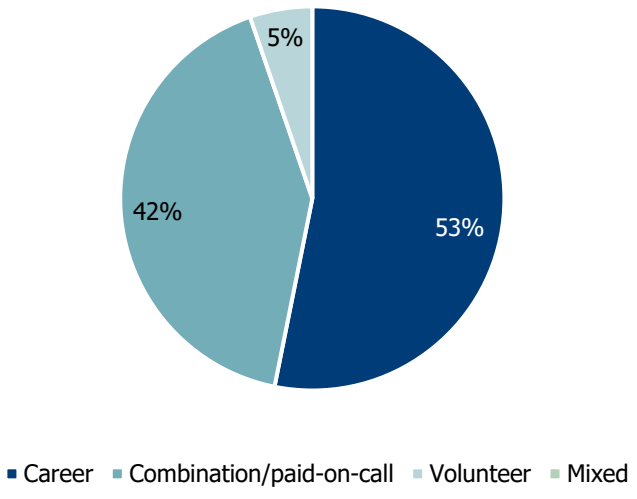


Figure C16. Ambulance organizational status in villages

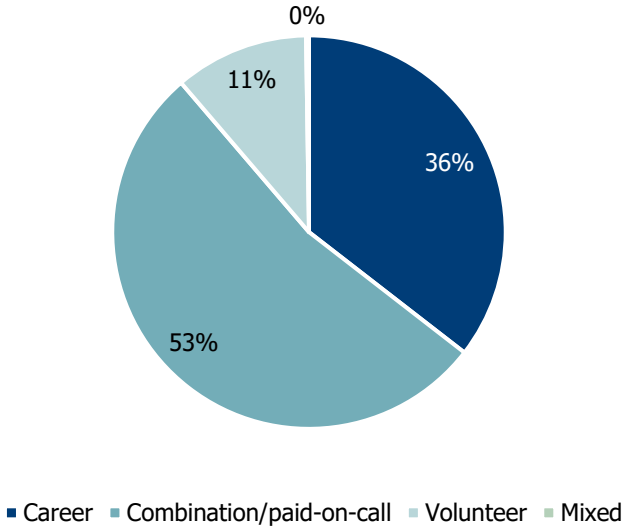
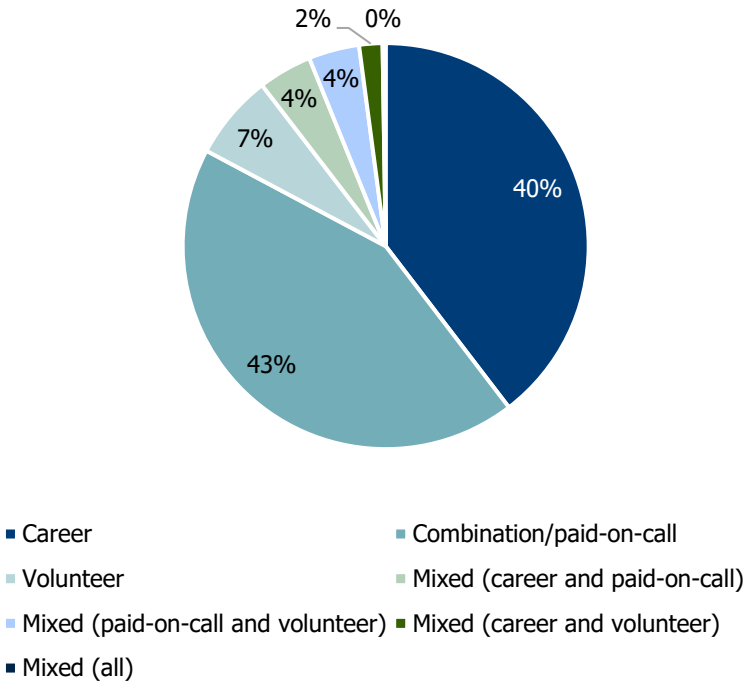


Figure C17. Ambulance service organizational status in towns



Comparing the number of towns served by each of the service organizational types to total number of towns does not yield as simple of a breakdown as it did for cities and villages. Because towns split their ambulance service among multiple providers more frequently than cities and villages, approximately 10% receive some of their coverage from two or more service providers with different organizational statuses.

Non-transporting service providers

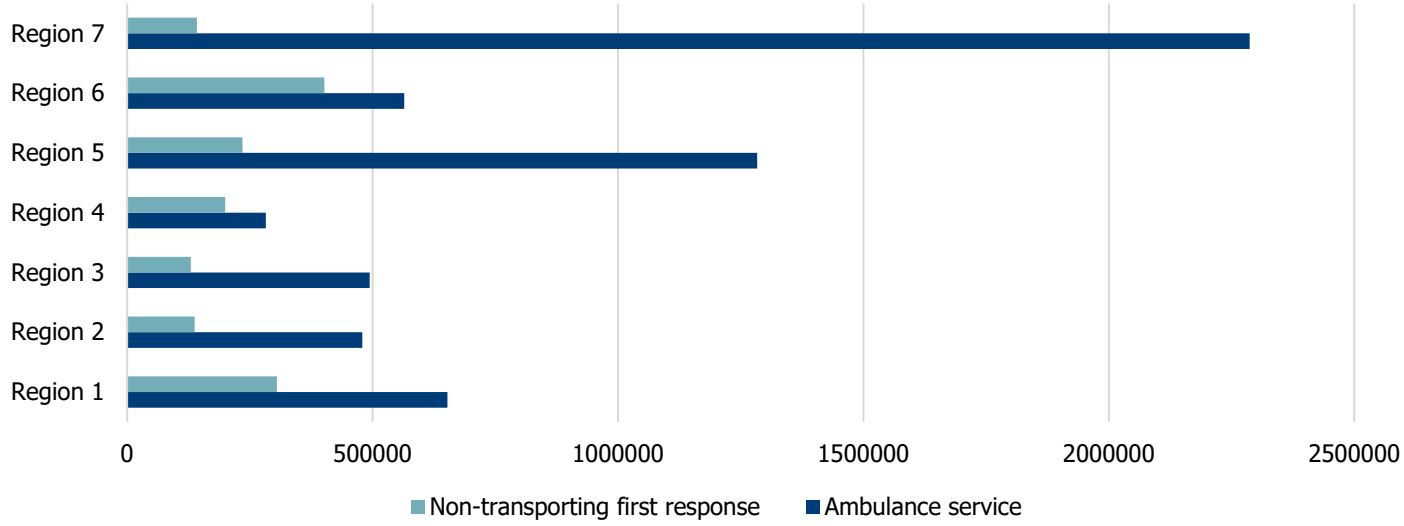
In addition to ambulance service protection, 911 resources are supplemented by non-transporting service providers in some parts of Wisconsin. These service providers are intended to arrive ahead of the ambulance and begin care, especially in areas where ambulance response may be prolonged. Unlike ambulance service, provision of first response by an independent non-transporting service provider is not universal to all municipalities. Independent non-transporting service providers serve only about a quarter of the state's population. Even when looking at overall number of municipalities served by non-transporting service providers, less than half (39.0%) of all municipalities utilize them. The percentage of municipalities with a non-transporting service provider protecting some portion was higher among towns (40.3%) and villages (41.0%) than cities (26.3%). For the remaining portions of the state, first response is provided (if at all) under the ambulance service provider itself.

This section will look at provision of non-transporting service providers through three perspectives: license level, organizational type, and organizational status. Organizational tax status is not included as all non-transporting service providers, except for a few private industrial EMR groups that exist outside the public 911 system, are either government or not-for-profit. As with ambulance service providers, results for each of the fields are independent of one another even when trends for multiple fields are referenced together.

The prevalence of non-transporting service providers varies widely by region. Regions where fire-based ambulance service providers are common tend to have a lower percentage of non-transporting

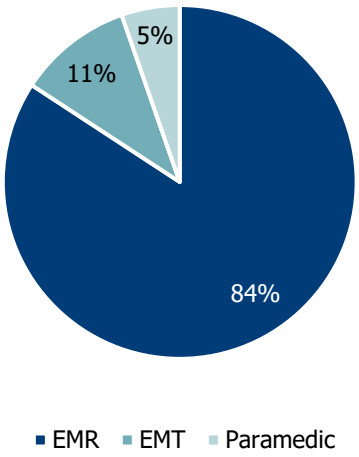
service providers. Conversely, regions with higher percentages of private or hospital-based ambulance service providers tend to have higher percentages of non-transporting service providers.

Figure C18. Population protected by ambuance service versus non-transporting service providers by region



Most non-transporting service providers are licensed at the EMR level. Smaller numbers are licensed at the EMT and paramedic levels. There were no non-transporting service providers licensed at either the AEMT or intermediate levels during the period evaluated.

Figure C19. Percentage of population in non-transporting service areas by license level



EMR service providers have special exemptions from licensing requirements common to other levels to make them more accessible to rural communities. These include exemption from 24/7 response requirement under Wis. Admin. Code § DHS 110.34(5) and limited patient care reporting requirements under Wis. Admin. Code § DHS 110.34(8).

Most people protected by a non-transporting service provider receive that protection through a fire-based service provider. This also helps explain why regions where fire-based ambulance service providers are most common tend to have lower numbers of people served by non-transporting service providers.

A slight majority of people protected by a non-transporting service provider receive protection from a volunteer service provider. This is a major difference from ambulance service providers, where the population serviced by volunteer service providers is very small.

Figure C20. Percentage of population in non-transporting service areas by organizational type

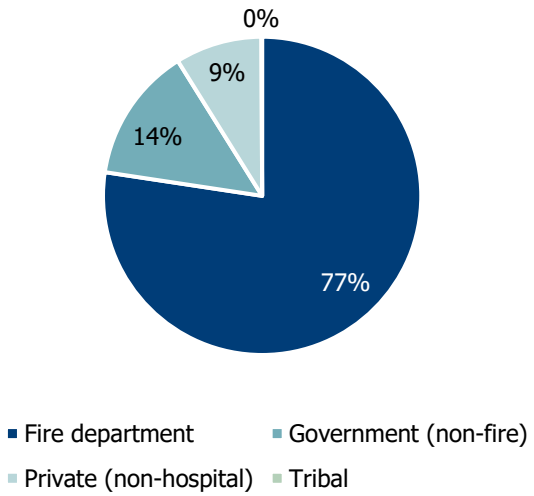
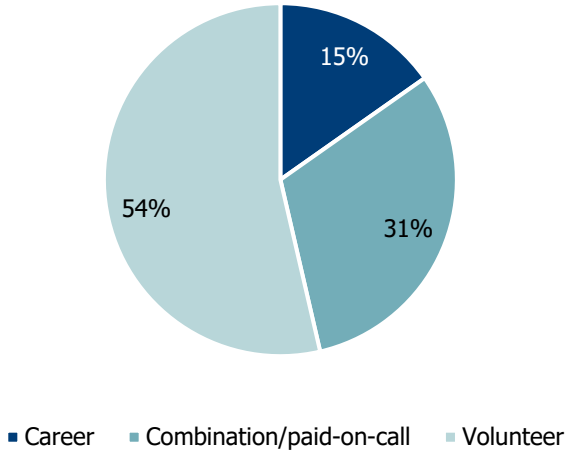
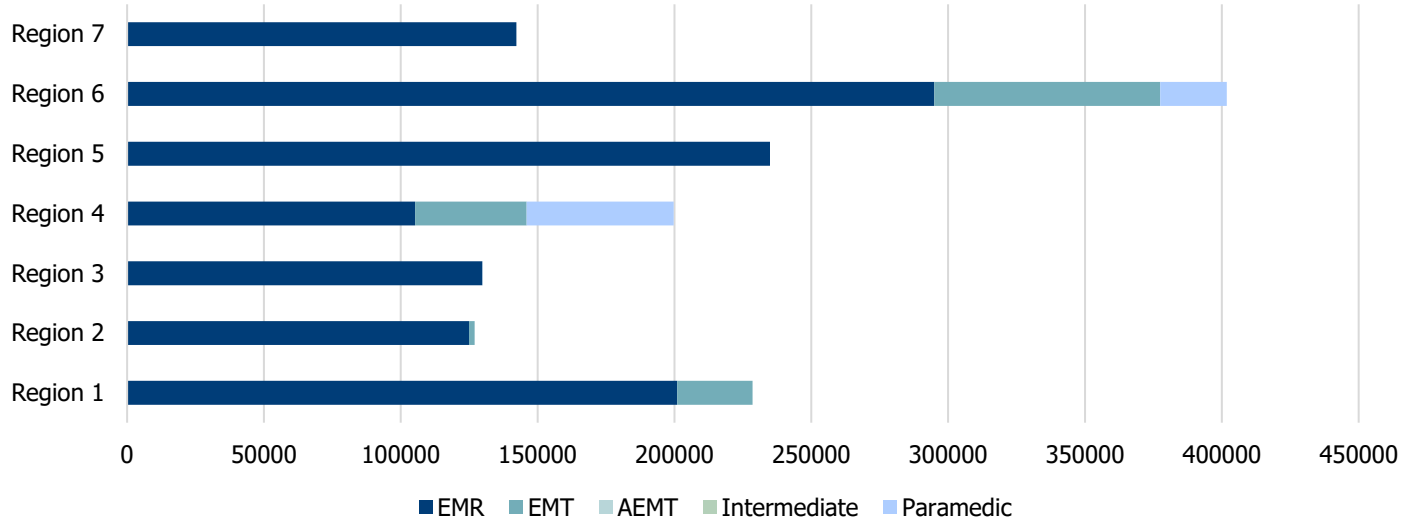


Figure C21. Percentage of population in non-transporting service areas by organizational status



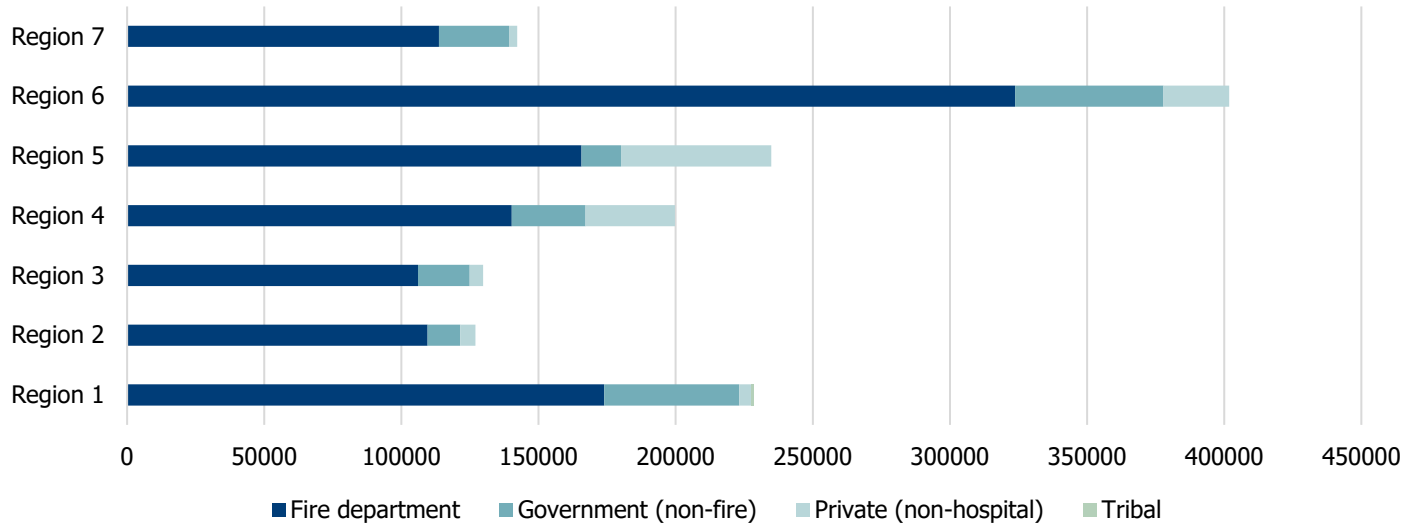
EMR is the most common license level for non-transporting service providers across all regions. Use of higher license levels was relatively more common among the fire departments in some regional cities served by regional ambulance services.

Figure C22. Regional breakdown of population serviced by non-transporting services providers by license level



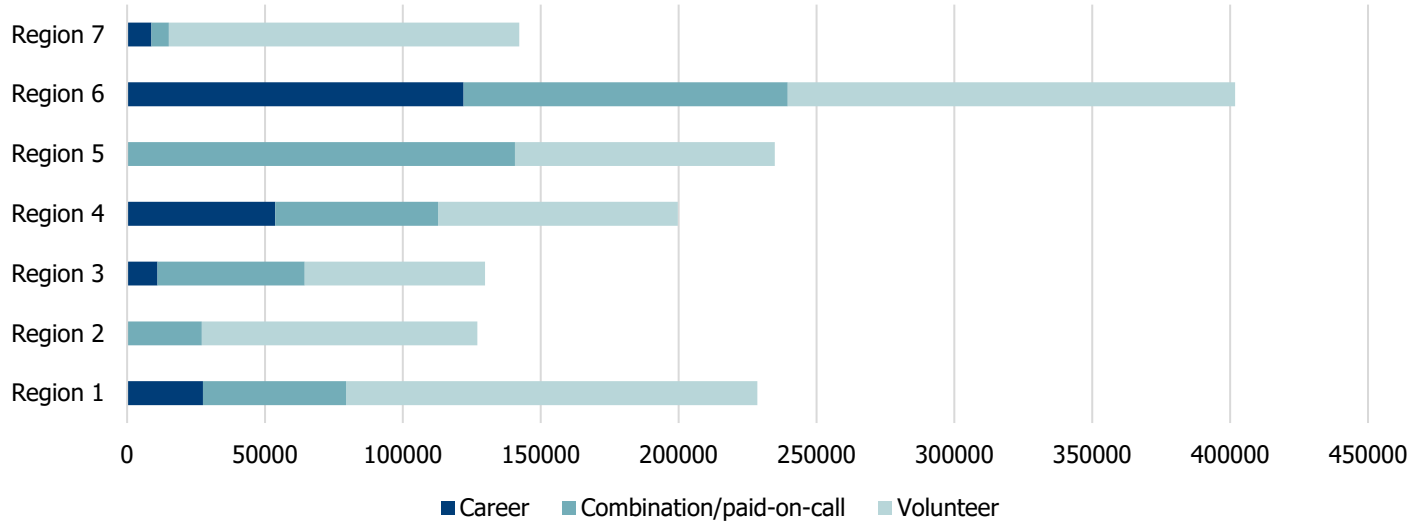
While fire department-based non-transporting service providers protected most people in every region, the prevalence of private and other governmental non-transporting service providers varied between the regions.

Figure C23. Regional breakdown of population serviced by non-transporting service providers by organizational type



While volunteer service providers protect the largest number of people statewide, regional variations in organizational status were strong. The regions where large, regional ambulance service providers were most common (Regions 1, 4, and 6) had much larger portions of the population served by career non-transporting service providers. This is largely due to career fire departments in larger cities within these regionalized ambulance service providers' primary service areas being licensed as non-transporting service providers.

Figure C24. Regional breakdown of population protected by non-transporting service providers by organizational status

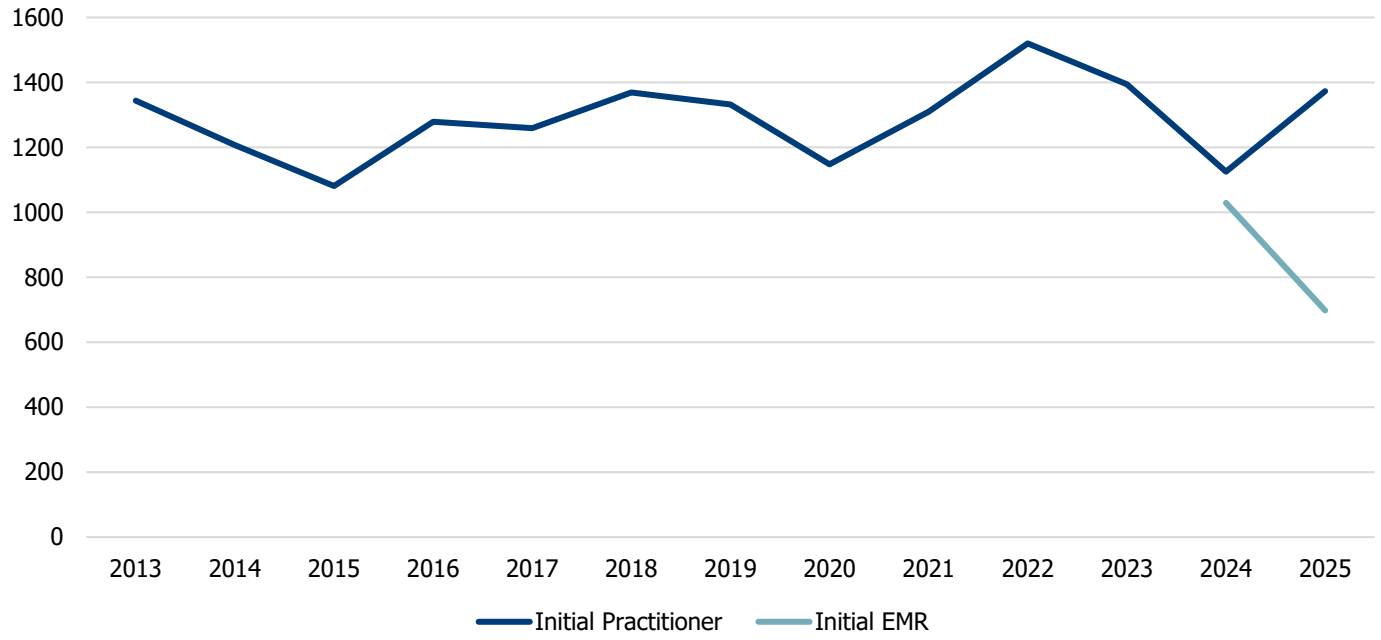


Appendix D—EMS Application Data

Certification and licensing remain the EMS Section's principal functions. The information in this appendix provides information on certification and licensing trends over time. Note that E-Licensing does not have the capability to reproduce data for previous points in time on demand.

Prior to 2024, the EMS Section used a single electronic application for both initial EMR certifications and initial EMT licenses. The EMS Section therefore has only limited separate EMR and EMT data for this period. Following the changes to EMR certification in 2024, the EMS Section created separate application processes for EMR and EMT. Note that as the new EMT application is also used by EMRs upgrading to the EMT level, there is overlap between EMR and EMT applicants in 2024 and 2025. The sum of EMR and EMT applicants therefore is greater than the number of actual new entrants to the EMS system in this period. While there are year-to-year fluctuations, initial applications have remained steady over the last decade.

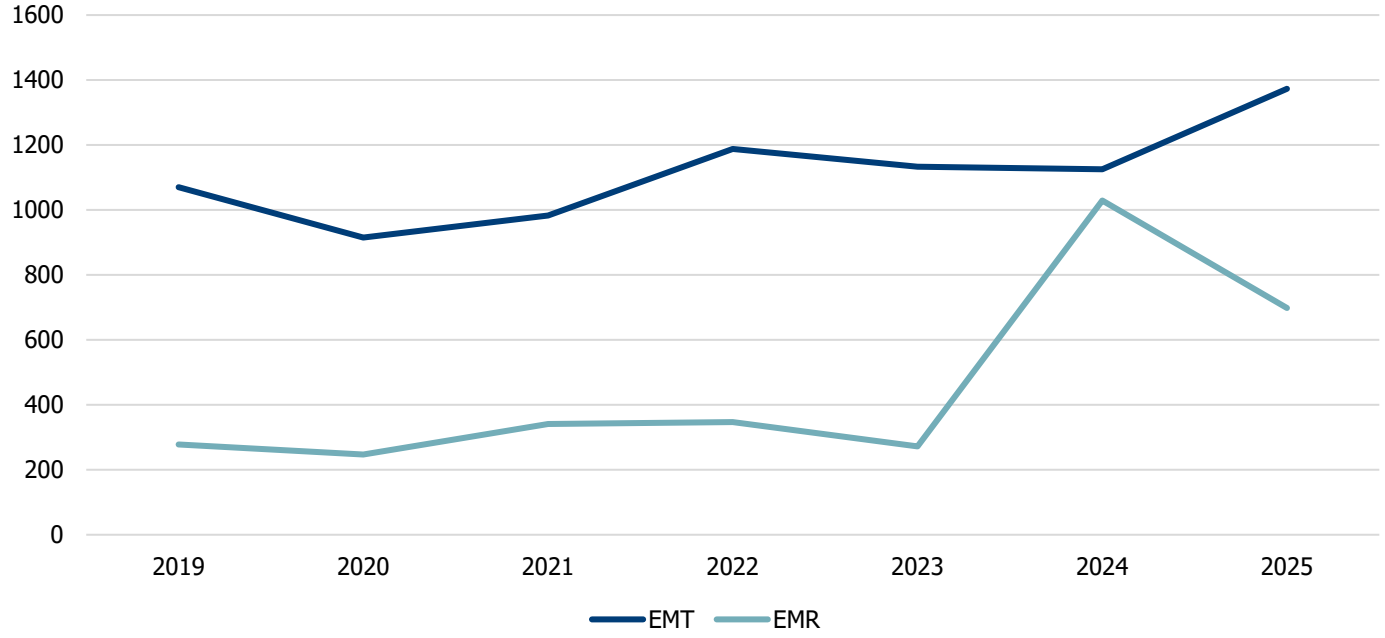
Figure D1. Initial certification and licensure applications, 2013–2025



With the changes to EMR certification requirements in 2024, the EMS Section attempted to delineate data for EMR and EMT applicants. As the previous application was not designed to delineate EMR and EMT data prior to 2024, that effort was only partially successful. The EMS Section could not readily query data from before 2019, nor can it discount the possibility of undercounting or other reliability issues for the limited data that could be gleaned from applications between 2019 and 2024. Despite those caveats, there was a pronounced rise in the EMR applications in 2024. After an especially strong first year under the new EMR certification requirements in 2024, however, EMR applications dropped by approximately a third in 2025. With only two years of data, there is still insufficient data to determine long-term trends to EMR.

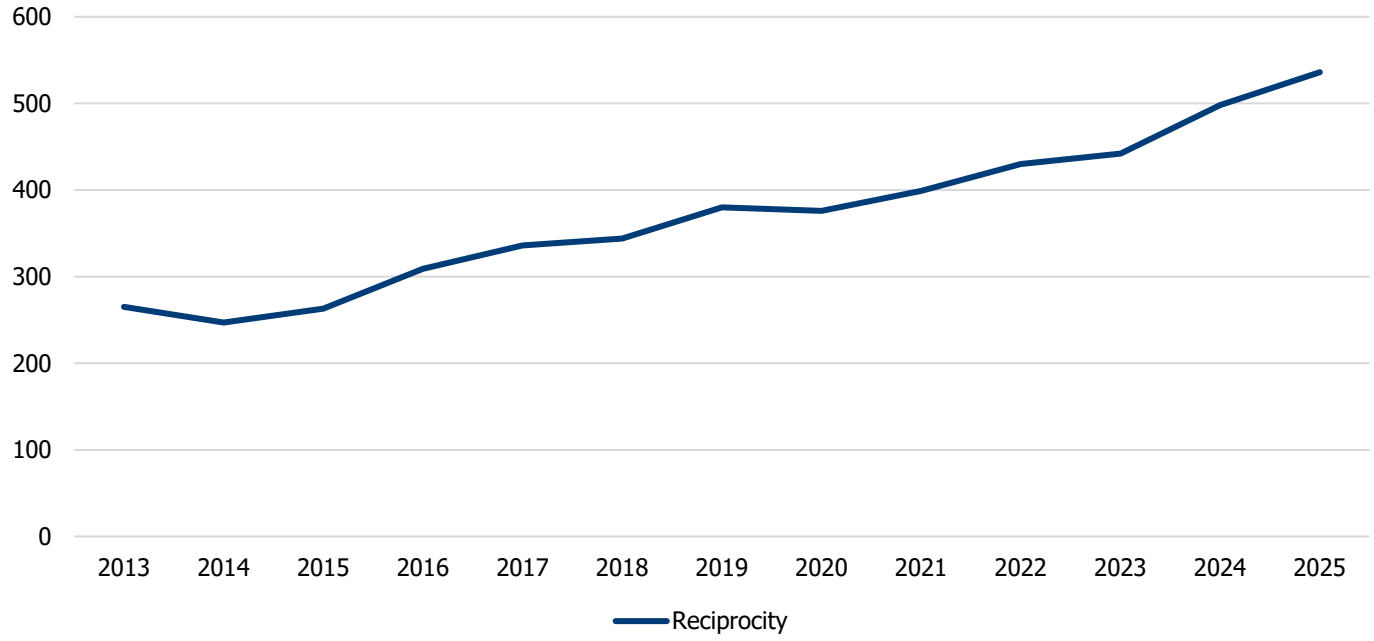
Likewise, definitively attributing this increase in EMR applications to any single cause is challenging as multiple factors changed simultaneously. In 2024, in addition to the changes in EMR certification requirements, EMR service providers first became eligible to directly receive FAP for SFY 2025. This resulted in millions of dollars hitherto unavailable to EMR service providers, including funds for new training new EMRs. Additionally, several new training centers opened between 2023 and 2025 offering additional opportunities for EMR training. Finally, an increasing number of training centers are now structuring their EMT courses as a two-part course where EMR training is embedded into EMT training. In these courses, the student can apply for an EMR certificate after completing that portion of the course. The student is eligible for EMT licensure after completing the remainder of the course and licensing requirements. While such courses have existed for more than a decade, relatively few individuals applied for EMR certification if pursuing EMT as they simply waited until full completion rather than complete the NREMT for EMR. With the changes in EMR certification, that barrier was removed resulting in more individuals applying for both EMR certification and EMT licensure. This trend is anticipated to continue as this class structure was adopted as standard in the new EMT curriculum published in 2024.

Figure D2. EMR and EMT Initial Applications, 2019–2025



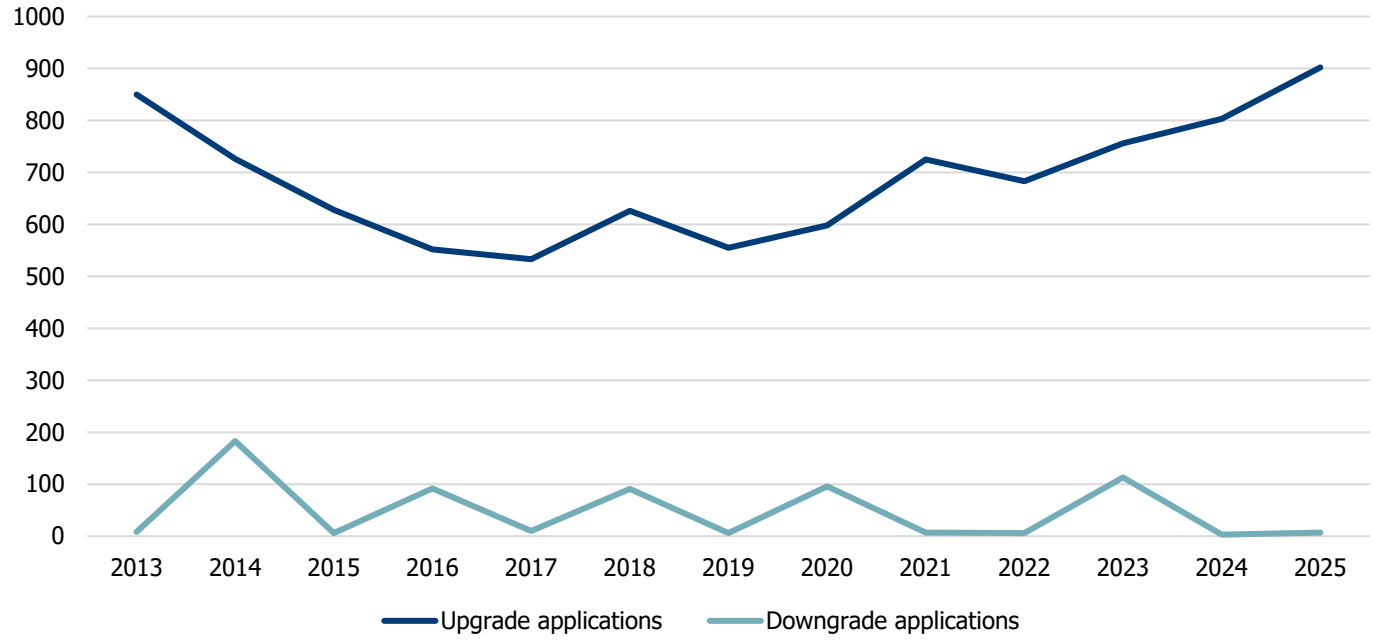
While applications from applicants with in-state education remained relatively steady, reciprocity applicants during the same period have grown steadily. Reciprocity applications doubled between 2013 and 2025.

Figure D3. Reciprocity applications, 2013–2026



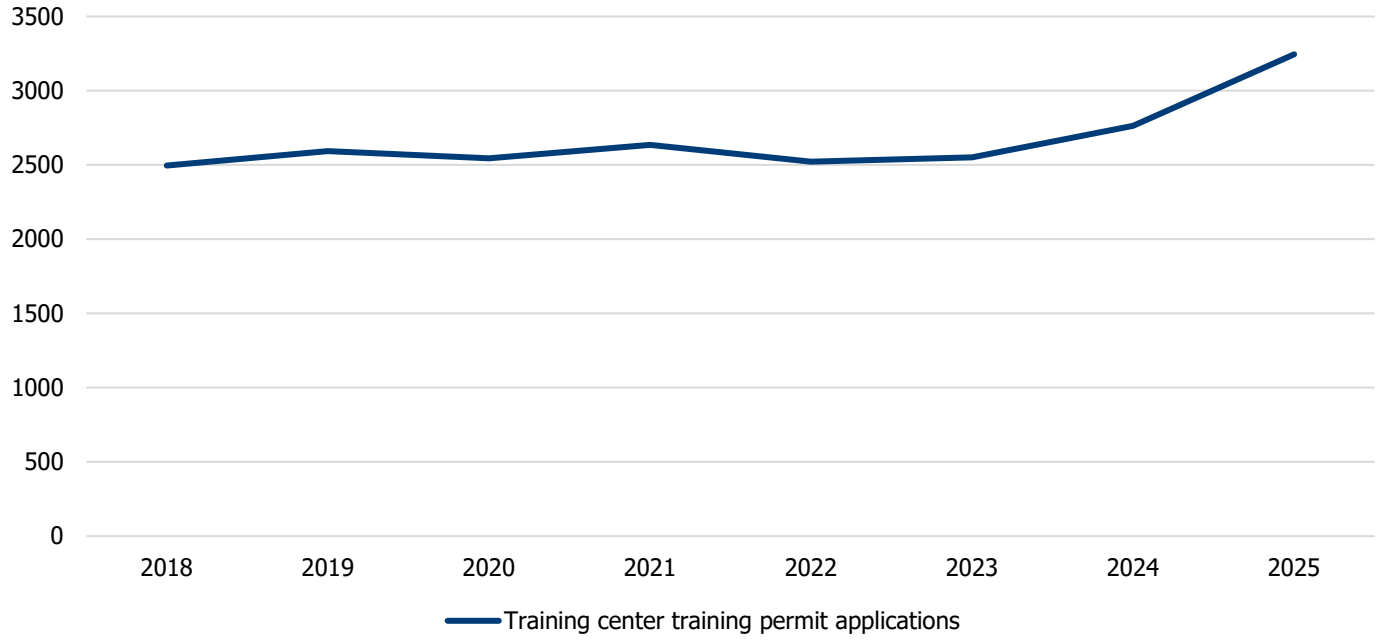
Every year hundreds of EMS professionals change their license levels. After several years of steep decline, applications to upgrade to higher license levels have trended upward. The number of individuals downgrading follows a pattern of peaking in renewal years (when individuals would need to complete the higher educational hours to higher license levels). The number of downgrades even in renewal years is small compared to other applicants.

Figure D4. Upgrade and downgrade applications, 2013–2026



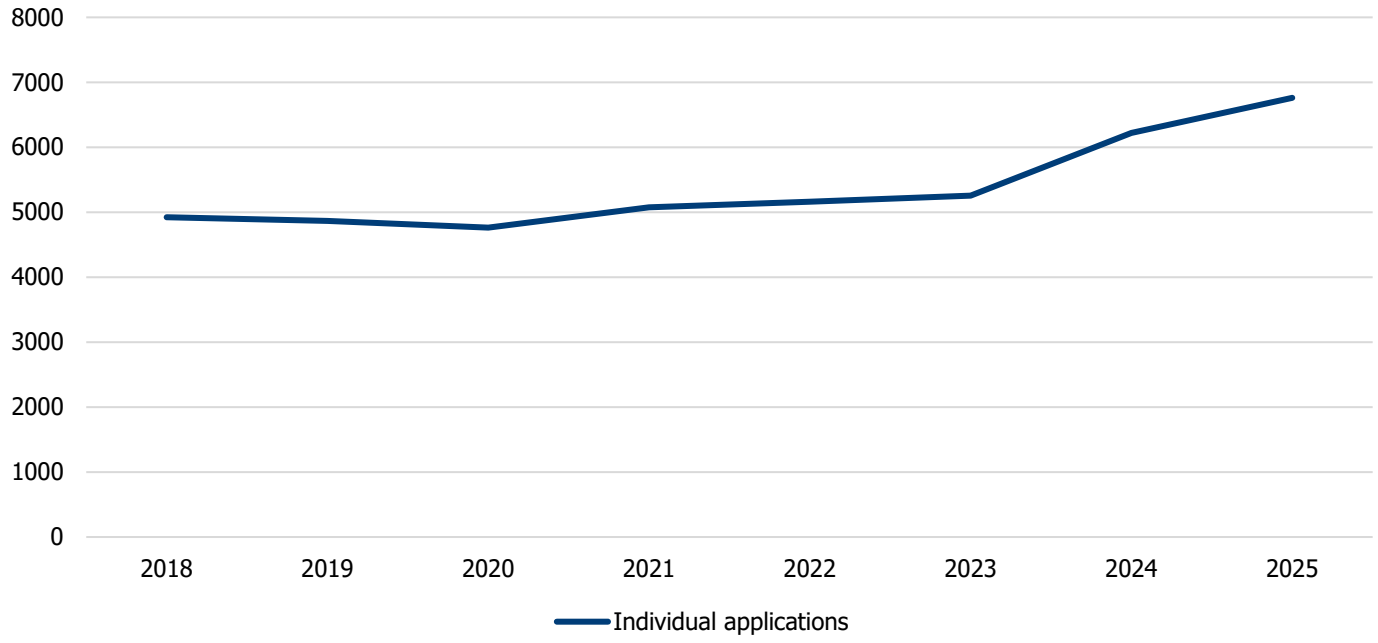
The EMS Section also issues training center training permits to individuals in EMS practitioner courses. EMR courses, which have no clinical component, do not have a training center training permit process. Applicants for training center training permits have been steady throughout the period.

Figure D5. Training center training permit applications, 2018–2025



Individual applications have increased significantly over the last several years. The EMS Section has thus far been able to absorb this increase but continued growth at this rate will press resources.

Figure D6. Total individual applications reviewed, 2018–2025



Appendix E—FAP data

FAP participation has grown extensively since the expansion of the program in SFY 2025. As transporting service providers have been eligible for many years and already participate at a high rate, most of the growth has been among non-transporting service providers.

Figure E1. Comparison of SFY 2024–SFY 2026 FAP

State Fiscal Year	Services Applying Transporting	Services Applying Non-transporting	Population Reported Transporting	Population Reported Non-transporting
2024	303	N/A	5,617,329	N/A
2025	322	174	5,653,216	734,466
2026	315	214	5,775,255	947,171

Ambulance service providers still constitute the largest number of FAP applicants and receive the largest portion of funds. However, non-transporting service providers were responsible for most of the growth in the number of applicants between the SFY 2025 and SFY 2026 FAP cycles.

Figure E2. Recipients by service type SFY 2025

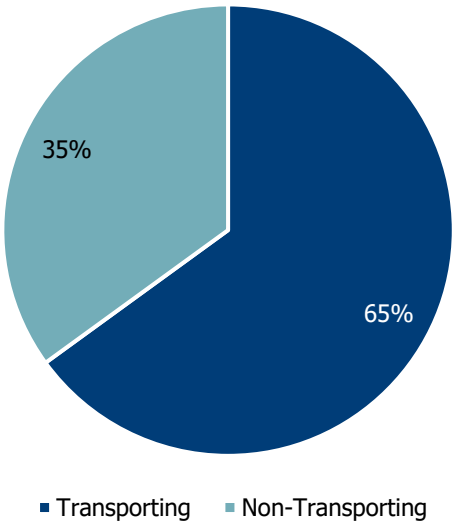
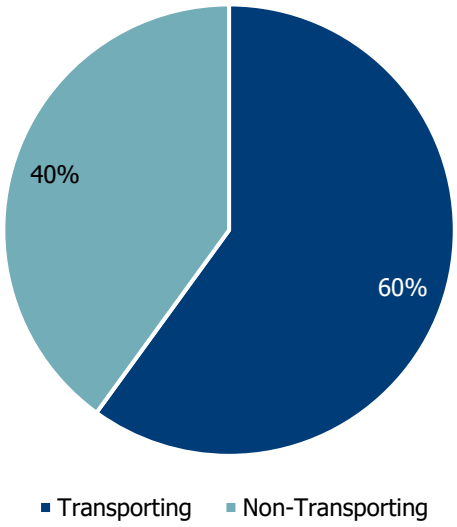


Figure E3. Recipients by service type SFY 2026



Despite the increased number of non-transporting service providers applying, higher populations and greater percentage applying for training and education funds among transporting service providers led to transporting service providers maintaining a similar share of overall FAP awards.

Figure E4. Funds distributed by service type SFY 2025

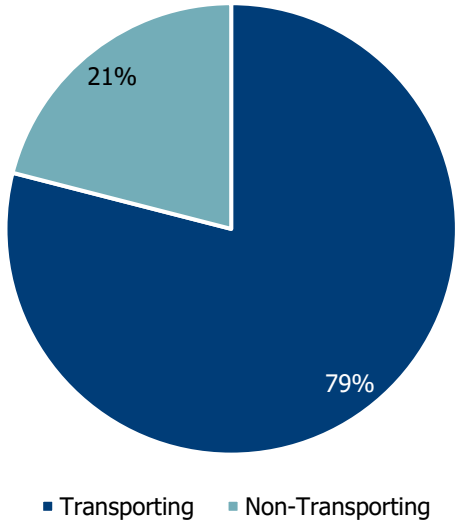
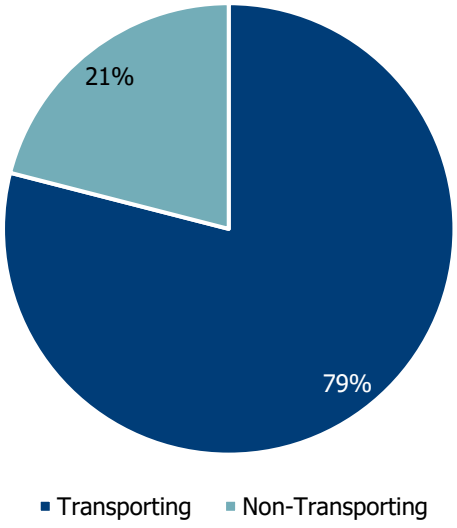
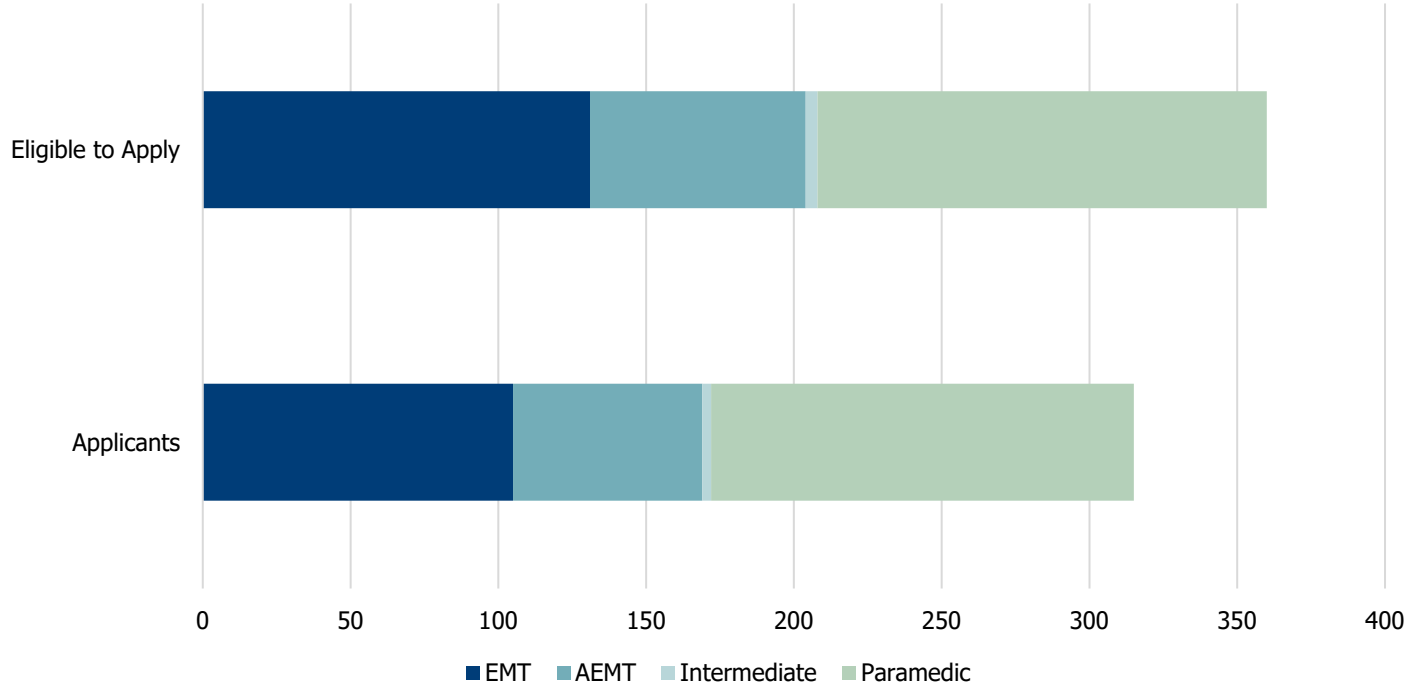


Figure E5. Funds distributed by service type SFY 2026



Transporting service providers in SFY 2026 continued to apply for FAP at a high rate. Approximately 87% of eligible transporting service providers applied for FAP in SFY 2026 which is a similar rate to previous cycles. The application rate was even higher among service providers licensed at higher levels.

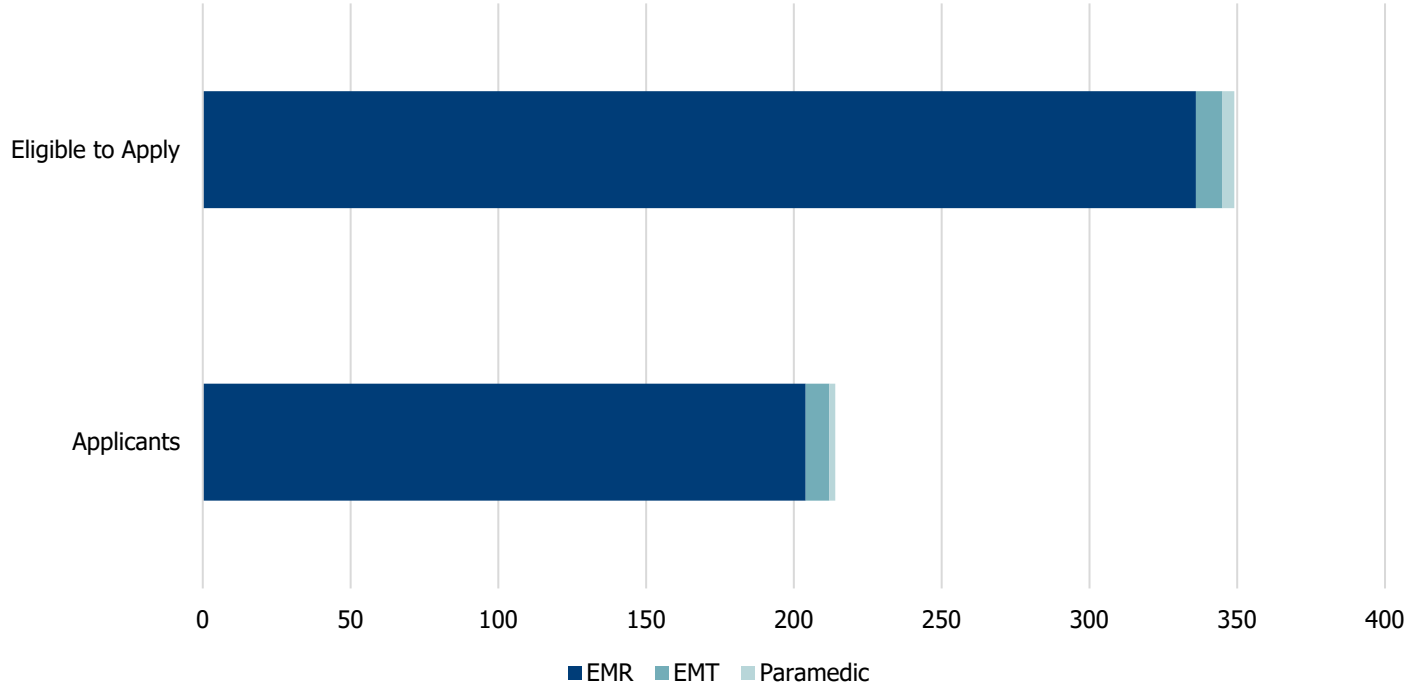
Figure E6. Transporting services



Despite the growth of applications among non-transporting service providers over SFY 2025, non-transporting service providers in SFY 2026 again continued to apply for FAP at a significantly lower

rate than transporting service providers. Approximately 61% of eligible non-transporting service providers applied for FAP in SFY 2026.

Figure E7. Non-transporting services



SFY 2026 continued to have a large percentage of all applications completed at end of the multi-week application period. Over 48% of all applicants applied in the last eight days of the application period.

Figure E8. Application Submissions

