TESTIMONY

TO THE

HOUSE VETERAN'S AFFAIRS & EMERGENCY PREPAREDNESS COMMITTEE

PENNSYLVANIA EMS SYSTEM IN CRISIS

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Good afternoon. Thank you for allowing me the opportunity to speak before this committee regarding the on-going EMS crisis in Pennsylvania. I am Adam Johnson, Director of Emergency Services for Cameron County. I am also an EMT, a volunteer fire chief, and the public safety program coordinator for the Northern Pennsylvania Regional College.

Cameron County has a population of 4,547 residents spread throughout 396 square miles. Approximately 28% of the population is 65 years or older. The county is covered by two EMS agencies: Cameron County Ambulance Service (Emporium) and the Sinnemahoning Fire Department (Sinnemahoning). The Cameron County Ambulance Service (CCAS) is staffed 24/7 with paid providers. In 2021 CCAS responded to 873 calls for service, 820 of them were 911 dispatches. The Sinnemahoning Fire Department is volunteer and has been out of service due to lack of manpower. The closest mutual aid EMS service is 20+ miles as is the closest hospital.

My intent today is to summarize some of the common obstacles faced in recruitment and retention as well as provide some insight into operational challenges faced by local EMS organizations. Most importantly, I hope to provide some perspective as to the nature of rural EMS.

The current EMS business model is failing to provide financial stability, regardless of the size or structure of the organization. The reimbursement rates for government payors are far below the actual cost of operations. Alternative funding such as fundraisers and subscription services can no longer keep up with the increasing operational costs. Since EMS systems have been historically self-sufficient, many municipal budgets lack funding for this type of service. While some

municipalities have utilized other funding sources such as Act 13 (Impact Fees) or ARPA funds, these are not sustainable sources.

Unlike other healthcare providers, EMS agencies cannot base staffing decisions on office hours. Requests for service occur at all hours, any day of the week. Also, unlike a staffed emergency room, the agency must go to the location of the patient, regardless of road conditions, inclimate weather, distance, or remoteness. EMS agencies must therefore be ready to respond 24/7, plan for the unexpected, and be properly equipped according to their response area. For example, given the remote locations faced by some EMS agencies, a four wheel drive ambulance may be necessary. This limits the type of ambulance being purchased and increases the overall cost. Since these remote locations are generally found in rural areas of the state, it is an increased cost on already financially distressed services.

In rural areas, transport times can be significant. Transporting 20, 30, or in some cases 50 miles one way removes the ambulance from service for long periods of time. Should another ambulance response be needed, the response time could be upwards of 30 mins and in some cases approaching 1 hour if mutual aid is requested. This places additional pressure on the system as mutual aid organizations are also facing the same difficulties.

As training hours and cost have increased, there are fewer certified providers coming into the EMS system. Should an individual choose to become an EMT, there are no incentives to remain in the local area. EMTs associated with rural agencies would find starting wages in the $10-$15 range or be asked to volunteer, although volunteer EMS agencies are becoming fewer every year. As available providers decrease, competition among agencies increases. This has resulted in the

closure of EMS agencies as the cost of operations becomes overwhelming.

This is where a missed opportunity occurred. When the COVID-19 PA Hazard Grant program was announced in July of 2020, many EMS agencies hoped that they would be eligible to provide an extra $3 per hour for the covered 10-week period for their employees. Unfortunately, no EMS agencies were awarded grants under this program. Since this program would have put money in the EMS provider's pockets, unlike other operational grant programs, it was seen as a lack of acknowledgement and support of their frontline duties.

The final SR 6 report detailed the reduction in available providers while also noting the highest losses in BLS agencies occurred in rural populations due in part to lack of available staffing. Additionally, it was recommended that EMS regulations be reviewed with consideration of factors involving economic conditions and geography. In April of 2019, I had requested a staffing waiver from the Bureau of EMS on behalf of CCAS based on the following scenarios:

A.) An ambulance is dispatched for a patient with difficulty breathing. The primary crew is not available as they are engaged on another emergency call. Only one off-duty EMT and a volunteer EMSVO is available. As this is not a BLS crew under the current regulations, the call is turned over to the next due/closest EMS agency (20+ miles away) causing a transport delay of 30 minutes.

B.) An ambulance is dispatched for a patient with difficulty breathing. The primary crew is not available as they are engaged on another emergency call. An off-duty EMT is available as well as a volunteer EMSVO. The crew responds in the second

ambulance, evaluates and treats the patient, and begins transport to the hospital intercepting with an ALS provider enroute, allowing for the ALS provider and EMT to finish transport.

At that time, regulations resulted in scenario A being played out on multiple occasions. Unfortunately, the Bureau felt it lacked the necessary authority to grant this waiver based on the requirements of the EMS Act. This type of restriction establishes an extraordinary set of circumstances that impairs the health, safety, and welfare of the public by delaying transport. One year later, the passage of Act 17 of 2020 corrected this issue; however, the waiver is temporary. I therefore urge you to support pending legislation making this authority permanent.

I will leave you with this recent example occurring within our county showing how these impacts can be compounded. The first EMS call was received at 1:02 PM with four additional calls being received over the next 50 minutes. The first, second, and fifth calls were handled by CCAS and the other two were covered by mutual aid. However, without the BLS staffing waiver, the second call would have been turned over to mutual aid further delaying response times.

Recommendations

1.) Continue to allow for BLS staffing waivers
   a.) As indicated previously, this waiver has allowed agencies to staff calls that would otherwise be turned over to mutual aid. Delaying patient care and/or transport is counter to the goal of the EMS system.
2.) Support/Co-sponsor Rep. Causer's medicaid reimbursement bill
   a.) Current reimbursement rates for ALS ($300) and BLS ($180) are inadequate. Additionally, providers should be paid for all loaded miles. Recent hospital diversion activity has resulted

in increased mileage that may not be reimbursed. Further, rural EMS agencies are transporting longer distances which is exacerbated by EMS agency and hospital closures.

3.) Adopt/create an EMR to EMT bridge course
   a.) Give classroom credit to EMRs wanting to seek EMT certification. This is an existing pipeline of potential EMTs that could be leveraged with a shorter training commitment. This should also result in a decreased cost of training.

4.) Clarify pre-arrival ambulance diversion criteria and authority
   a.) The EMS system is over utilized as a means of transport to the hospital for non-emergent conditions. These calls tie-up resources that would otherwise be available for emergency responses.
   b.) Current BLS protocols allow for PSAP/911 diversion prior to arrival based on EMD protocols. Unless diverted by the PSAP/911 center, calls are based solely on a first-come, first-served basis. It appears as though some PSAPs are hesitant to divert resources. Additional research into pre-arrival diversion based on call classification by the field units should occur.
   c.) Criteria and guidance should be developed to ensure pre-arrival diversion is appropriate and not based on patient specific information (i.e. name, address, call history).

I appreciate the committee's interest in finding solutions to the EMS crisis and once again thank you for the opportunity to provide a rural perspective on the issue.