Testimony by David Tupponce to the Pennsylvania House Majority Policy Committee
October 11, 2022

Policy Committee members,

Many people believe that when they suffer from a medical emergency, they can call 9-1-1 and a well-trained Emergency Medical Services (EMS) professional will appear within moments to whisk them to a nearby hospital. Increasingly, for many people in rural Pennsylvania communities, that belief has become a fantasy.

As you have heard, Pennsylvania's fragmented and underfunded EMS system is a part of a larger national problem that often leaves patients in rural communities at risk of long waits due to too few ambulances for too large a geography. Whether due to difficulty repairing or replacing vehicles or the inability to recruit and retain crews due to low wages, EMS is in crisis.

But there are other impacts of our struggling EMS system that get less attention than the initial patient transport to the hospital. Five days ago, one of my nurse managers relayed a story that a patient in our ICU needed to be transferred to another hospital to receive a procedure not available locally. On October 6 at 1AM we were given a bed assignment at the accepting hospital. We contacted the ambulance service and were told that the patient would be picked up around 8AM. When we were still waiting at 4:30PM, another call was placed and we were told that it would now be later that evening before the patient would be picked up. When midnight came and no ambulance had arrived, another call revealed that they were having difficulty freeing up an ambulance crew for the transport and they would try again in the morning. At 4AM on October 7, we received a call from the receiving hospital saying that it was over 24 hours since the bed had been assigned and since the patient hadn't arrived, they had to give the bed to another patient. And we're back to finding a bed somewhere.

This example is by no means unusual. The same challenges can arise when transferring a patient to a nursing home or other post-hospital facility. And the longer the trip, the longer the ambulance and crew remain unavailable to serve other emergencies in their community. The results are negative impacts on patient outcomes and longer lengths of stay which increases hospital costs with no increase in reimbursement for the care. Our inability to transfer or discharge patients even keeps patients in the Emergency Room waiting for a bed to open up so they can be admitted.

Even if our community members manage to get an ambulance, they may end up with large bills despite insurance (also known as "Balance billing") . It's a problem that was dodged by last year's No Surprises Act when it passed the issue to the newly created Ground Ambulance and Patient Billing Advisory Committee. But almost a year later there has been no discernible activity from that committee.

What can we do? The solutions are not simple and require ideas from all stakeholders, including patients, EMS providers, hospitals, insurers, and legislators. Increasing reimbursement rates for ambulance services only address one piece of the problem. And how do we pay for it? Common local solutions in rural communities like subscriptions or property tax increases for EMS services often fail due to low population density and relatively low property values. Without bold ideas at the state and federal level to assist us, many rural communities may find that the fantasy of ambulance service has become a nightmare.

Thank you,

David Tupponce, MD
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