PA House Majority Policy Committee Hearing
"Health Care Issues in Rural Pennsylvania"
January 19, 2022 at 9:30 am
University of Pittsburgh at Bradford
300 Campus Drive Bradford, PA 16701

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PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS

January 18, 2022

Re: Pennsylvania House Majority Policy Committee Public Hearing on Health Care Issues in Rural Pennsylvania

Rep. Martin Causer, Rep. Kathy Rapp and members of the House Republican Policy Committee, we thank you for the opportunity to share our insights on the health care issues facing rural Pennsylvania and how Community Health Centers FQHC serve a vital role as part of the safety-net network to provide critical services to individuals across the Commonwealth who might otherwise have difficulty accessing care. For purposes of this testimony, it is important to note that 40% of Pennsylvania's nearly 350 health center sites serve rural populations.

Background

The mission of Keystone Rural Health Consortia (KRHC) is to provide quality, affordable, accessible and comprehensive health services to the counties we serve. KRHC serves Elk, Cameron, McKean and Centre counties with medical offices in Emporium and Ridgway and dental offices in Emporium, Kersey, Johnsonburg and Kane and we will be adding a dental office in Bradford. KRHC not only growing in the number of locations, but in the amount of people we serve. Since 2016 we've seen a 40% increase in the number of people cared for by KRHC. And every year 75% of the population we care for are at 200% of the Federal Poverty Level or below.

Keystone Rural Health Consortia is a of the Pennsylvania Association of Community Health Centers (PACHC), which represents Community Health Centers (also known as Federally Qualified Health Centers (FQHCs)), FQHC Look-Alikes and Rural Health Clinics (RHCs) throughout Pennsylvania. FQHCs comprise the largest network of primary care providers in both the state and the nation. These health centers are held to nearly 100 federal requirements to become and maintain their status as FQHCs – some of which include minimum number of hours of operation, quality assurance standards and location in an underserved area. Community Health Centers offer access to quality primary medical, dental and behavioral health care for individuals and families. Health center services include basic primary medical care, oral health care, diagnostic lab and radiology services, prenatal care, cancer and other disease screenings, immunizations, pharmaceutical services, enrollment assistance, treatment for substance use disorders and many others.

Community Health Centers are open to all, including privately insured, Medicare, Medicaid and the uninsured and currently serve one in 14 Pennsylvanians. If a patient is uninsured, the cost of services provided by the health center is based on the patient's family size and income through a sliding fee discount program. Our average patient is working poor – an individual who is employed but their employer is unable to provide insurance, or it is too costly for the individual. Our health centers also serve veterans, and we have a rural health center site that is specifically dedicated to doing so.

There are currently more than 350 FQHC sites in 54 of the Commonwealth's counties operated by these non-profit community organizations. You will find FQHCs in both rural and urban underserved areas of the Commonwealth. In aggregate, FQHCs provide quality care to more than 890,000 Pennsylvanians, many of whom would have difficulty accessing health care absent their local community health center.

Community health centers also often serve as the first line of surveillance and response to public health needs, especially for the most vulnerable.

Our health centers are only able to locate in areas that are federally designated as Medically Underserved Areas (MUAs) or Health Professional Shortage Areas (HPSAs)—areas of highest need. FQHCs are successful in part because of the federal requirement that these non-profit community-based organizations have a patient majority board. That is, at least 51 percent of an FQHC's governing board must be patients of the health center to keep the FQHC responsive to their community and community need.

Overall Perspective of Rural Health

Health care for rural communities has always posed unique and additional challenges. In April 2018 I, along with Dr. Michael Colli, Keystone's Chief Medical Officer, testified at a joint meeting of the House and Senate Health Committees on the needs of rural health care. Many of the issues that were brought up in 2018 remain issues today: workforce, broadband access and technology, transportation, substance use disorders, lack of access to dental care and behavioral health services. These issues have been further exacerbated by the continuing pandemic...but progress has been made in some of these areas and opportunities for improvement in the long- and short-term do exist.

Telehealth: The pandemic in general has had a tremendous impact on health care. One of the biggest positives is that the pandemic has advanced the use of telehealth in providing health care services much faster than we thought possible, and with quality outcomes. KRHC has found telehealth to be extremely helpful in reaching those patients that have not been able or wanted to leave their house during the pandemic and for those struggling with increased mental health issues due to the pandemic. Transportation has also been one of our biggest barriers in this area, telehealth has enabled us to bridge that gap as well. Unfortunately for FQHCs and the Pennsylvanians we serve telehealth may go away in Pennsylvania once the waiver expires on March 31, 2022. To be clear, it's not that we can't offer the service. It's the fact that we would not be able to get reimbursement for the services under the Medicaid program after that date. That's half of our patient population. A population that has come to rely on the ability to connect with their health care provider remotely. Another key component of telehealth, particularly in rural Pennsylvania, is the ability to provide care through an audio-only option. Many of our clients don't have access to the technology to conduct a virtual telehealth visit or do not have access to broadband to conduct such a visit. The need for the option to use audio-only telehealth service is compounded by the lack of access to public transportation to reach in-person appointments. Telehealth has been particularly beneficial to our behavioral health clients. **Solution:** Telehealth, including audio-only services, needs to remain an option in how health care is delivered.

Workforce: Workforce was, and continues to be, one of the biggest challenges facing health care providers throughout rural Pennsylvania. The simple issue is "There aren't enough..." There aren't enough physicians, physician assistants, nurse practitioners, nurses, psychiatrists and psychologists, dentists and dental hygienists, social workers, medical assistants, dental assistants, aides, etc. Name the position and there's a shortage. That's why programs such as the Pennsylvania's Primary Care Practitioner Loan Repayment Program and the Pennsylvania Primary Care Career Center—a partnership of the Department of Health and PACHC—are so critical. In the last five years the Career Center placed 95 primary care professionals including physicians, dentists, nurse practitioners and physician assistants in underserved communities. That's more than 200,000 patient visits per year thanks to commonwealth-funded recruiting. A major tool in this recruiting is the Pennsylvania loan repayment program. Despite the success of this program, the funding for this program has remained stagnant for the last seven years.

Programs like these allow rural health centers to compete with our urban counterparts for these critical health care professionals. The best part is, once they come to rural Pennsylvania they stay. We have seen an almost 80% retention rate for providers placed through this program. It works. **Solution:** Invest in the Primary Care Practitioner Loan Repayment Program.

Dental Care: Access to dental care continues to be an important issue across Rural Pennsylvania. That's why Keystone has made a commitment to opening dental clinics. KRHC currently operates four dental offices in our service area and will open Bradford, PA, our fifth site, once we are able to recruit a dentist. The recruitment of a dentist has been extremely challenging and has pushed back our opening date 9-12 months. A person's oral health directly impacts their physical health. However, for people on Medicaid, finding dental care for themselves and their children in nearly impossible. The dental clinic run by one of my colleagues in a rural county in Pennsylvania serves patients from 19 counties because there is no rural dental care, and the majority of dentists don't take Medicaid. **Solution:** Support programs like the Primary Care Practitioner Loan Repayment Program, allow for teledentistry and allow public health hygienists to do school screenings.

As I mentioned above, there are a lot more issues facing rural health care providers and health care providers in general. All of which have been impacted by the COVID-19 pandemic. Know that FQHCs remain committed to being part of the solution. Since I testified on this topic in 2018, Pennsylvania has added more than 50 additional FQHC locations across the state. The first case of COVID was discovered by an FQHC in Wayne County. Since that time, Keystone and the FQHCs in Pennsylvania have been battling COVID, offering testing and vaccinations, all while continuing to work to meet the health care needs of patients and our entire communities.

Conclusion

Thank you for the opportunity to discuss our thoughts on rural health needs and we hope that they help to provide background information for future discussions of healthcare needs. I am glad to answer any questions you may have or provide you with additional information. For information from a statewide perspective, feel free to contact Eric Kiehl, PACHC Director of Policy and Partnership at eric@pachc.org or 717-599-2077.

Sincerely,

Kristie Bennardi
Chief Executive Officer
Keystone Rural Health Consortia

Hello, and thank you for your time.

By way of introduction, my name is Chris Benson. I've been a Registered Nurse for over 10 years, with the majority of that time concurrently serving on my local EMS program as an Advanced Life Support Pre-Hospital RN, and the last 6 years concurrently as a flight nurse and ambulance staff. This has allowed me to enter into private residences, physician offices, outpatient clinics, and Emergency Departments, hospital Medical/Surgical units, Intensive Care Units, and surgical suites in hospitals of all sizes throughout much of Western Pennsylvania, Upstate New York, Eastern Ohio, and portions of Western Maryland. I've spoken with staff members of a wide range of specialties individually, interacted with them through national and international nursing conferences both as a participant and presenter, and more importantly been one of them. I've also been a captive (and held captive) audience with patients undergoing EMS transport, and been a first-hand witness to their concerns and frustrations. I have cared for the infant that has been abused to the point of questionable survivability, older adults who have had their life prolonged well passed any meaningful quality and only due to the whims of family members, have seen both high quality and frustratingly low quality of care in primary care offices and hospitals, and been the transporting nurse provider for the critically ill and injured at all stages from initial dispatch to air medical and receiving nurse. In addition to that I've worked to further my education, chasing my Master's degree in Nursing with a focus on becoming a rural Family Nurse Practitioner. These experiences have led to an in-depth and personal understanding of the challenges of rural healthcare disparities that cannot come from reading a report or study. They have also led to seeking ways to confront that disparity definitively, and with minimal impact to the majority of stakeholders.

Bluntly stated, from my experiences and interactions it would seem that too much voice is given to the wrong stakeholders. Healthcare delivery organizations and insurance companies need to have a voice at the table due to the assets involved, but not enough voice is given to those most deeply impacted by the decisions made: chiefly, the staff of the organizations and the patients. While I can not and do not to presume to speak for everyone from these demographics, I can speak to certain noticeable trends. And to be honest, I'm wondering just how a country bumpkin as comfortable on a farm tractor working my family's fields as providing some of the most advanced critical care nursing treatments came to be pushed into such a situation as I'm now endeavoring to undertake. What I **do** know is that without significant change from all stakeholders, healthcare in the United States is at a tipping point to where the status quo has become unsustainable; that situation puts my family, my friends, my patients, and my colleagues at tremendous risk.

In this document, I will be bringing to your attention insights, experiences, and information from my career and educational pursuits. The document will be broken down into four sections: Problems, Solutions, a section of highlighted topic points consisting of both problems and solutions, and a References section for validation of the information presented.

Within the Problems and Solutions sections, the superscripts correspond to the References section article links.

Problems

Private Health Insurance

One of the trends that is extremely significant is that of insurance. Americans spend more than five times the amount of other nations on all combined types of insurance premiums each year[1]. This accounts for approximately ¼ to ½ of the average American family's monthly income[2], far more than any other expense including housing, food, and utilities. It is important to note that this only accounts only for insurance premiums (as opposed to deductibles and copays), and the impact of all types of liability insurance on the household budget from factoring in liability insurance for transport agencies supplying goods and materials, manufacturing, and all other forms of production and delivery is incalculable. When compared to all other domestic products, insurance in America is the single largest expenditure by far not only for families, but all other industries combined.

Of this number, health insurance is one of the largest expenditures by American families, and yet the financial stability impact is negligible at best. Health insurance premiums outpaced income gains by 26% over the decade ranging from 2010-2020[3], well into the implementation of the Affordable Care Act in 2010. Additionally, health insurance premiums outpaced even inflation during that time period[4]. In comparison, healthcare costs have increased by 68% over that same timeframe[5]. Interestingly, despite federal limitations mandating that at least 80% of premiums go to reimbursements, private insurers reported repeated record profits up until 2020, the start of the COVID pandemic. This translates to a net change from 84.5% to 82.6% loss ratio, or almost 2% lower payouts in 2020 versus 2011 respectively[6]. More notably, this is a drastic change of the 95% loss ratio in 1993, before changing from non-profit to for-profit entities[7] that subsequently transitioned to publicly traded corporations.

This translates into drastically lower reimbursements to hospitals for care given to patients, which in turn leads to hospitals charging more for supplies and care rendered. The difference, of course, is then passed on to the patient. Occasionally, if the patient is savvy enough and has the resources available, the balance bill can be negotiated downwards, especially if the patient kept track of the supplies used during the course of their care or provided their own.

Another frustration by providers is that bills submitted to insurance are not reviewed by healthcare professionals, but rather persons that may only have been a high school graduate holding a certificate of course completion for medical billing and coding. Providers report increasing frustration over ordering tests or treatments, having the insurance refuse, then the provider personally having to call and argue the case for the test or treatment to someone not qualified to do the same. This contributes to job dissatisfaction and turnover among providers

due to the fact that having to engage in such a practice requires the provider to take additional time away from actually seeing and treating patients.

Not only have hospitals and patients seen decreasing reimbursements and climbing premiums, but in order to further cut expenditures an alarming situation is arising; private health insurers are purchasing controlling interests in healthcare organizations and private physician practices[8,9]. In Pennsylvania, this translates to Anthem/Blue Cross purchasing and rebranding Allegany Health Network, a sizeable interest in Geisinger Health System, and an interest in Kaleida Health System (partner with Upper Allegany Health System, which owns Bradford Regional Medical Center). As the primary purpose of any business is to improve income while mitigating expenditures, it can easily be recognized that it will not be the insurer or the hospital bearing the brunt of the expense mitigation, but rather the patients and staff.

Healthcare Delivery Organizations

Insurers are not the only entities responsible for challenges to healthcare access. When the Affordable Care Act was enacted, many smaller hospitals were forced to either close or sell due to the restructuring of the reimbursement systems. Prior to implementation of the act, many of the smaller hospitals providing care to medically underserved communities were able to take advantage of 110% reimbursements from the Centers for Medicare/Medicaid Services (CMS), which not only completely reimbursed them for the care of those requiring government funded insurance, but also allowed them to reinvest the overpayment into increasing capabilities and offerings of the hospital. With the restructuring, now CMS payments have decreased to only a *possible* 90% maximum reimbursement. This 90% reimbursement leads to a shortfall in the total amount of care provided, and is based on multiple factors that mean most hospitals actually are reimbursed less than the maximum. This led to most of the smaller hospitals across the country being forced to sell to larger organizations. In rural Western Pennsylvania, this translates primarily to University of Pittsburgh Medical Center (UPMC), Allegany Health Network (AGH), Geisinger Health System (GHS), Penn Highlands Health System (PHHS), and Kaleida Health System (KHS).

Literature regarding the impact of larger organization delivery care charges is mixed. Overall, it does not have a statistically significant difference on overall net healthcare costs annually[10], but the literature does not overly specify between for-profit hospitals and non-profit organizations, nor overall between safety net organizations and non-safety net organizations. Information on overall changes in quality of care is also mixed across the literature. However, one concerning trend in Western Pennsylvania is the cessation of services within acquired hospitals.

Healthcare delivery organizations, chiefly the actual hospitals, need to have a voice in regards to healthcare offerings. However, as these smaller hospitals are acquired by the larger organizations, the individual voices are effectively stifled through the more powerful voices of the leadership of the organization. More importantly, the complaints of the patients are not

heard over the overarching voices of organizational leadership. The reason that this is concerning is due to the relationship of compliance with insurability and acceptability by providers.

As organizations decide to centralize care offerings, especially in regards to specialties, increased burdens are placed upon the care seeking patient. These burdens involve (but are not limited to) increased cost in seeking care due to vehicle maintenance and fuel; increased time off from work; issues with arranging care for dependents; meal planning while seeking care; and weather concerns while transiting to care[11]. Imagine, for instance, living in the lake effect snow belt of Bradford, PA but needing to see specialists in Erie, PA or Buffalo, NY and the day of your appointment, 18 inches of snow is predicted. If the patient breaks too many appointments, it is up to the discretion of the insurance provider and/or the healthcare delivery organization to determine the patient to be noncompliant. Should that designation be made, then the patient can expect further decreased access to care and insurance.

Additionally to the closure of outpatient specialties, limiting the amount of inpatient beds also has a significant effect on patients requiring care. Lack of beds leads to interfacility transports, typically by Emergency Medical Services, and which Pennsylvania has made increasingly complex by an extremely strict definition of a critical care transport crew. Not only is an accepting physician at another hospital necessary, but also the space, equipment, and staff needed to accommodate that patient both at the receiving facility and during transport. On top of that, insurance concerns further complicate matters, and healthcare organizations serve an additional layer of frustration. Another concern is transportation costs. It is not unheard of for insurance to refuse payment for initial patient visit if the patient and provider agree that the patient can travel safely to another institution via personal vehicle, but if the patient does not meet ambulance criteria, reimbursement may also be refused and the patient left to foot the bill. Additionally, it is not uncommon for a patient that undergoes private vehicle transit be refused admittance at the receiving hospital due to lack of continuity in care while en route. CMS requirements are some of the most stringent in this regard, but referring staff often lack the knowledge to have such a discussion with the patient, lack familiarity with transfer paperwork to assist transport agencies with recouping funds, and lack awareness of insurance parameters for transport when deciding an acceptable receiving facility. And when the insurance network and the healthcare organization networks are at odds, often the patient is left in the lurch entirely.

On top of the complexities of limiting specialty healthcare services, several of these organizations have internal issues that cause concern among both patients and staff. Both Penn Highlands and Upper Allegany Health Systems not only cut services to outlying hospitals with the intent of transferring patients to the "mother ship", but then failed to adequately prepare for the influx. Penn Highlands DuBois had to shut down a portion of their Cardiac Intensive Care Unit due to inappropriate staffing, and Upper Allegany Health System's staffing and bed availability has caused long waits and transfers outside not only their organization, but

their partner organization of Kaleida Health as well. PHS was able to partially rectify the situation by engaging travel nurse agencies before the pandemic, but with UAHS the closure happened around the time of an upswing of cases in the region. Because of that, along with the now obvious organizational poor planning combined with a lack of interest in nurses working for Olean General Hospital's toxic environment, the situation at Upper Allegany should now be considered dire.

The environment at OGH is so egregious that travelling nurses have many times refused to complete their contract and walked out. Part of this is due to unsafe staffing, where two Registered Nurses and a "team" of a Licensed Practical Nurse and two Nurse's Aids care for more than ten patients each. Despite such a workload, I personally have spoken with staff nurses who reported they were in on their day off after being sent home to prevent labor law violations, yet were told they needed to come in on their day off-uncompensated, amidst threats of termination of their job-to finish their documentation to prevent actions being taken against the organization by governing bodies. This in itself is a labor law violation, not only of state law but also federal law. Interestingly, despite constantly crying "poor" UAHS and PHS routinely leave portions of even the decreased reimbursements of the Affordable Care Act on the table by not adequately addressing their staffing issues and thereby failing to meet Quality of Care Metrics for maximum reimbursement. UAHS, in particular, fails every single metric under the ACA.

However, they are not alone in their staffing concerns. UPMC staff have some of the highest turnover rates in the Commonwealth, largely due to staff being able to take similar positions with better compensation elsewhere. Now, with travel nursing being so appealing due to the pandemic, it is being revealed that staff across the professions and across the nation have been inappropriately undercompensated. Travelers report that even in jobs where the financial compensation only (as opposed to including meals, lodging, and incentives) is similar to what they were making in their initial positions, they are able to match their retirement contributions *and* employer match as well as find better quality and lower priced insurance than what was offered by the original employers-a situation especially true of the UPMC organization.

This comes while hospital organizations publicly lament insufficient funding, juxtaposed to the Helicopter Emergency Medical Services (HEMS) colloquialism "all hospitals have cranes". Even before the pandemic, staff members were speaking out against superficial improvements to facilities, inability to provide the level of care to which we were trained, executive bonuses and compensation afforded to the detriment of the staff providing the work, and leadership that devalued the input of staff. Also, in order to limit organizational liability, it is common practice among many healthcare organizations to attempt to push liability for situations upon the staff, rather than keep it at the organizational level. One instance of this occurring was at Cole Memorial in Coudersport (now UPMC Cole). In the Intensive Care Unit, both of the Registered Nurses on duty were in patient rooms attending to patient needs. Despite repeated

formal requests for additional staff to monitor cardiac monitors and telemetry units, the organization refused. During this particular instance, one of the monitors began to alarm due to a non-life-sustaining cardiac rhythm. Each of the nurses thought the other was addressing the cause of the alarm and therefore continued their care, and the patient with the dysrhythmia ultimately ended up dying due to lack of attention. Cole Memorial leadership initially fired both nurses due to not attending to the alarm, and it was only through legal action at the personal expense of the nurses that they were able to resume their jobs.

Healthcare Staff

A major cause for concern among nurses is staffing and timing of events. All hospital organizations regularly schedule meetings, trainings, and competency checks during regular business hours. This causes nurses on evening and overnight shifts to prolong the amount of time that they are on duty, or trade at least a portion and often a full day off to attend these requirements. Additionally, hospitals are under pressure from the Affordable Care Act to constantly improve their patient satisfaction scores, which leads to staff being verbally, mentally, and even physically abused. Because of the emphasis on patient satisfaction scores, nurses reporting such assaults normally have their complaints swept under the rug. On top of that, nurses in particular are often contacted outside of working hours to answer questions on patient care, determine availability for working overtime, or be notified of other schedule changes.

Combining the stress of not being able to turn off work during days off, increasing organizational pressure to complete more tasks while on shift, bullying and assault by patients that does not get reported to authorities, bullying and assault by other employees that does not get reported to authorities (one of my friends from nursing school had a surgeon get impatient with her and throw a used scalpel at her that subsequently impaled itself in her hand, with the response from hospital leadership being "how could you have better anticipated the needs of the surgeon and prevented this from happening?"), feelings of being treated as a number and not a person by the organization, and lack of input on organizational movements has led to a mass exodus of nurses prior to the pandemic. Indeed, the COVID pandemic actually exacerbated healthcare staff leaving their respective professions entirely, not only transitioning from traditional bedside roles-to the tune of half a million healthcare professionals leaving respective healthcare professions altogether by the end of August 2021[12], compared to a projected 500,000 Registered Nurses leaving the bedside by then end of 2022 in a 2020 prediction. (In comparison, only 133,000 will graduate from nursing school, with a portion of those failing to be successful at passing their boards.) This has caused and will cause more overtime, more contacts outside of working hours, and more pressure to perform for those remaining. It is a downward spiral that contributes to the allure of travel nursing, where one is able to try out different "flavors" of healthcare delivery organizations without long term commitment in an ongoing pursuit of finding an organization that allows sufficient work/life

balance, professional autonomy and input, and practice to the level of care to which staff trained.

Another cause for concern among healthcare staff is increased documentation requirements. Partially due to requirements enacted through the ACA, time spent documenting patient care has steadily increased, which leaves less time available for direct patient care. As noted previously, this leaves the staff faced with a dilemma: perform the care first and hope that there is sufficient time and memory to be able to accurately document, or give substandard care and focus on hitting documentation benchmarks. While working in the ER, lower acuity patients typically required approximately 30 minutes of documentation each during a 3-4 hour stay, while more critical patients may require care to documentation ratios approaching 1:1. In the EMS realm, the rule of thumb that I teach new hires is that for every hour on the road, expect 15-30 minutes of charting. Therefore, during busy shifts in either field, it is not uncommon to have to stay over after a shift to complete documentation, which further contributes to job dissatisfaction when faced with meeting organizational deadlines or missing out on personal events.

Medical Specialties

One of the most difficult disparities for rural patients is access to specialist care. This in particular is one of the most difficult situations facing nearly all stakeholders in the healthcare debate. Rural areas typically are lower income, and in regards to facilities and equipment, under supplied. Rural specialists report a decreased amount of autonomy over their ability to manage patients, as well as increased burnout due to a higher ratio of patients to providers[13]. The high turnover has led to an overall loss of most specialties to rural Pennsylvania regions, notably with the exception of cancer care. This also contributes to the need to transfer patients from smaller, more rural hospitals to larger facilities.

Notably, one of the most difficult specialties to access is inpatient psychiatric care, to the point where the first step in an interfacility transfer is first to locate a center with an available bed, rather than first locating an accepting physician like would be the case for every other interfacility patient transfer. This is not unique to Pennsylvania, but rather an extremely acute problem across the United States. Since the 1950s, inpatient psychiatric facilities have been closing due to a heavy focus on "deinstitutionalizing" patients. Part of this was justifiable due to reports of abuse of psychiatric patients by staff. However, it has also contributed to homelessness (estimates of acute psychiatric illness range from 25-40% of homeless persons, depending on literature source), drug abuse, and other public health concerns. In the acute care medical world, it has also contributed to extreme difficulty in locating psychiatric placement for acute psychiatric needs[14]. I personally have had patients waiting for days in the Emergency Department, having called every single psychiatric unit within the Commonwealth of Pennsylvania in an attempt to obtain placement.

Some of these patients are awaiting voluntary inpatient evaluation, while others are involuntary and held by court order. When I say "involuntary", I mean that they can and will do everything within their power to get out of going to a psychiatric institution, requiring physical restraint, chemical restraint, and the addition of extra staff to keep not only the patient safe, but also caregivers. This contributes to an unwillingness of psychiatric centers from accepting many of these patients, due to the high potential for violence against staff. Unfortunately, this means that the patient in need of acute inpatient psychiatric care on an involuntary basis must then be seen by a psychiatrist (how do you have the patient seen by a psychiatrist when none are around?) in order to keep them held on an involuntary basis, or released back out in the midst of a psychotic episode that usually (but not always) is able to be medically managed with the appropriate care and support.

It needs to be pointed out that in the acute care world, patients are not considered for long-term psychiatric placement, but rather short-term placement until symptoms are better correlated to the appropriate diagnosis, medical treatment for that diagnosis initiated, and support systems are started. However, there is a particular subset of the psychiatric patient population that cannot either care for themselves adequately without intensive and prolonged individual care, or refrain from physical harm against themselves or others. With the continued closure of long term psychiatric facilities, it is an unfortunate projection that more of these patients will end up dead due to inability to adequately care for themselves, engage in harm against themselves, or be killed while engaging in harm against others either through the self defense of the victim or through a negative encounter with law enforcement officers.

Emergency Medical Services/Interfacility Transports

As previously stated, the problems encountered in rural healthcare delivery not only affect the outpatient world, the inpatient world, and office and hospital staff, but also Emergency Medical Services as well. Since the 1970s, volunteerism has declined precipitously in the United States, forcing EMS systems to increasingly transition to paid services or a combination of paid/volunteer services. However, even that is facing a concerning situation. EMS is facing staff leaving in increasing numbers, with the COVID pandemic escalating rates of departure while graduation rates fail to keep up with need.

Additionally, the wages of EMS providers have not been keeping pace with the cost of living for several years, especially in Pennsylvania. EMS providers generally only hold a certificate, although some organizations and educational institutions have been working to create a college degree pathway that allows for better pay that would be comparable to other healthcare professionals. However, this is still very early in the process, and the lower pay rates often have EMTs and Paramedics working multiple jobs to make ends meet. In many cases, this equates to working multiple full time jobs, leaving one 12-24 hour shift to go directly to another. EMT-Basics, in particular, earn only slightly higher than minimum wage, and could easily earn significantly more with less personal liability in a different career path.

While federally prohibited by the National Highway Traffic Safety Administration (NHTSA) from working more than 12 consecutive hours, similar to over the road truckers, emergency responders are able to get around this prohibition through the use of separate employers. Additionally, the dearth of responders keeps employers from asking questions about whether or not employees are working multiple consecutive shifts at different agencies. The primary consideration of this situation is the likelihood of being involved in a motor vehicle crash, but there is also the consideration of the effects of fatigue on patient care. National accreditation agencies require that if an employee works over the federal threshold, that there be an organizational rest period where the employee is permitted several hours of uninterrupted downtime before having to once again respond. Obviously, call volume and the quantity of employees, not to mention actually paying an employee to sleep, make such a situation unappealing to most EMS agencies.

In addition, ambulance services nationwide are facing closure due to financial implications both prior to and exacerbated by the pandemic. Unlike other First Responder agencies, the Emergency Medical System primarily receives its funding from CMS and private insurance reimbursements rather than primarily through the tax base. Notably, the majority of private insurance corporations base their reimbursements off from CMS standards and figures. This means that often, agencies lose money once supplies begin being used due to the fact that reimbursements are based off from three main figures: 911 dispatch versus interfacility transport, the level of care being provided, and the loaded patient mileage. The level of care provided is divided into Basic Life Support, Advanced Life Support I, Advanced Life Support II, and Critical Care/Specialty Care. This carries through all the way from BLS volunteer companies to Critical Care Ground and air medical. This means that agencies engaging in 911 response and interfacility transport are reimbursed not for the work that is performed or the supplies used, but on the number of miles the patient is transported. It is therefore possible, and in many situations likely, where the cost of transporting a critically ill or injured patient costs the agency far more than the reimbursement received. In the case of interfacility transfers, it also means that the patient must have a physician document the medical reasons that the patient is being transported by ambulance and can not be transported by any other means, as well as why the patient is being transported by ambulance to the receiving facility. If CMS determines that the patient could be treated at a facility closer than the actual receiving facility, then reimbursement is only supplied at the mileage to the closest facility, rather than the actual receiving facility. Frustratingly, both CMS and private insurers do not utilize EMS nor even general healthcare specialists when reviewing billing; indeed, those performing the reviews typically do not even require a degree, but rather a certificate of course completion in coding and/or billing. Therefore, many of the nuances involving appropriateness of destination are lost upon the individual perusing the chart for reimbursement purposes.

Notably, the COVID pandemic persuaded CMS administrators to review the reimbursement schedule to allow additional reimbursements and criteria, but it is still

undetermined whether those changes will be permanent or if the old fee scheduling system will be reinstituted once the healthcare system is able to better stabilize[15].

There is also the burden of physical distance between qualified treatment facilities. For much of Western Pennsylvania, from the time of initial injury and activation of EMS, it can take as much as 30 minutes before first responders arrive on scene. From that point, additional resources can be obtained, but at a time cost. Especially in regards to HEMS activation, there is the delay in relaying the request from the local 911 center to the HEMS dispatch center, a further delay in activating the HEMS crew, and then even more delay while the HEMS crew is in transit. Compounding the issue, Level II trauma centers and stroke centers are often in excess of a 20 minute flight, meaning that it is normal for a patient to finally reach an appropriate destination an hour after the initial medical insult. For those unfamiliar with the "Golden Hour" of trauma, after which survivability severely decreases after the initial injury, it is apparent how location can be a problem to access. Even West Virginia is largely better suited to emergency medical care, especially when confounding weather issues come in to play such as lake effect storms from Lake Erie.

Complicating matters, Pennsylvania statutes require that only authorized EMS Command Physicians can provide orders to EMS staff. Regulations at multiple levels also dictate that transports only occur at the discretion of the agency's command physician. However, this situation can become problematic when a referring physician desires a particular level of ambulance transport, usually higher than required under CMS reimbursement guidelines. In situations where the EMS agency's command physician is more of a figurehead than an active member of the EMS agency, this means that the crew must attempt to negotiate with the referring physician while also trying to explain fee structures to the patient. Part of this is due to the fact that crews have no idea what the actual fees will be; it is not a topic covered at any orientation that I have attended. Also at the crew level, this means that most crews simply don't argue with the referring physician, which can set the agency, the referring physician, and potentially the referring organization up for charges of fraud, not to mention loss of needed revenue for the agency. (To be perfectly honest, even I am unable to accurately represent any of my employing agencies' fee reimbursement structures.) In rare occasions, it is possible that the receiving facility determine the transport level needed for the patient, although this usually falls under the Specialty Care Transport criteria and involves specialized transport teams.

Drug Pricing and Shortages

In recent years, prescription drug pricing has made headlines due to corporations falsely inflating the cost of life-sustaining prescription drugs such as Epi Pens and insulin. There is justifiable outrage over such practices, and organizations should be held accountable for false inflation such as this. However, commonly prescribed medications have had their prices outpace inflation for decades-even after the passing of the ACA[16]. While being a problem for all Americans, it is especially troublesome for those receiving CMS assistance and those requiring

cancer care or emergency care such as thrombectomy ("clot busting") medications. Also contributing to increasing drug prices are Group Purchasing Organizations and both real and pseudo-shortages.

Currently, drug manufacturers are not regulated in regards to setting their own pricing on medications. Arguments against the practice are met with the rebuttal of the cost of research and development, as well as the cost of producing the medications[17]. In some cases, the argument has been made that for certain medications, the drug should be intentionally priced high so that prescribers weigh the financial impact of the medication against the patient's actual need for the medication in order to mitigate over-utilization of known teratogenic drugs.

One problem with this situation is that typically drug manufacturing is limited to few areas, which can lead to vulnerability in the supply chain and a resulting shortage. One poignant example of such a case was after Hurricane Maria devastated Puerto Rico in 2017 and caused a national shortage of Normal Saline[18]. The resulting loss of manufacturing leads not only to immediate shortage and price jumps, but also a sustained price increase in order for the manufacturer to recoup the costs of rebuilding the facilities and tools required.

However, a contributing group to drug costs and availability are the Group Purchasing Organizations (GPOs)[19]. Originally developed in 1910, these organizations were able to make a profit by saving hospitals time and therefore money researching costs of supplies, medical devices, and medications. Over time, these organizations developed increasing leverage not only to manufacturers in regards to their offerings, but also over the hospitals themselves through the means of sole-supplier contracts[20]. In the case of manufacturers, GPOs began to offer guaranteed purchase of products, a practice that increased dramatically after the passage of the 1972 Anti-Kick Back Statute. This has led to competition among healthcare delivery organizations competing financially for products, not to the manufacturer but rather to the middle-man GPOs. If a localized crisis causes shortages of a medical device or medication in one area, this often can lead to healthcare organizations offering premium pricing to their respective GPO in order to guarantee availability, creating a pseudo-shortage to other healthcare organizations. In the case of rural healthcare, due to insufficient funding for whatever underlying cause, the result is inability of the smaller organizations to ensure adequate supply of products-especially when in competition with larger organizations.

Combined, the situation has progressed to the point where life-sustaining medications are frequently in short supply-even before the COVID pandemic. On 10January2022, the list of medications on the FDA's Drug Shortage List numbered approximately 180, and included such medications as Propofol (commonly used for sedation of patients requiring endotracheal intubation), Atropine (used in cardiac arrest), Epinephrine (used in cardiac arrest, cardiogenic shock, and allergic reaction), and many common antibiotics of various routes of delivery[21]. I have seen the list stretch to over 200 medications on active shortage in recent years.

Additionally, the FDA has at times approved medications to be utilized passed their listed expiration date in an attempt to mitigate shortages.

Notably, the Strategic National Stockpile, the U.S.'s Federal stockpile of essential medications, has historically been used primarily to ensure availability of medications needed to respond to chemical or biological attacks. The medications contained therein are limited in number, and not of sufficient quantity to ensure uninterrupted supply chain for manufacturing disruptions, nor ongoing pandemics, but rather for initial primary response to the attack[22]. This means that healthcare organizations and emergency response networks are dependent upon suppliers and manufacturers, which have been unable to keep up with demand for various reasons. It has led to alternative therapies that may be untested, of increasing complexity, or of dubious effectiveness.

General Public

Ironically, the general public also has a role to play in rural healthcare disparities. Some of this is willful, in regards to knowingly being noncompliant with treatment regimens out of laziness and thereby contributing to provider frustration. Some of it is out of ignorance, such as when a family wants all possible measures taken to prolong the life of a patient who has no cognitive function nor quality of life. Frequently it occurs when there are viable lifestyle changes that would better manage a patient's condition, but instead of engaging those changes to effect meaningful treatment, the patient prefers medical management to mitigate symptoms. More frequently however, caregivers leaving the local professions or medical care altogether boils down to two big areas: litigation concerns and abuse of the professionals.

Frequently, due to pressure from organizational leadership to see more patients, providers (physicians, nurse practitioners, and/or physician's assistants) take on more and more patients. Many studies have linked this phenomenon on its own to job dissatisfaction and burnout, but there is also real concern for justifiable malpractice lawsuits[23]. To mitigate the potential for a lawsuit, providers sometimes acquiesce to performing a test demanded by the patient that they know will not have any merit, or conversely will order tests merely to stave off a potential lawsuit. Tort reform and malpractice reform have reduced the occurrence of such a practice, although it does still happen all too often[24]. It is important to note that this threat, either expressed by a patient or merely perceived by the provider, is ubiquitous in both more urban locations as well as rural locations.

One of the more concerning trends however, is that of verbal, emotional, and physical abuse against caregivers in all roles by patients and/or family members. In 2017, while attending my first ever Emergency Nurses Association annual conference, this trend was directly confronted. 100% of nurses in attendance signaled that they had been physically assaulted within the last 5 years, and it wasn't until the threshold was lowered to the last 6 months that less than half of those in attendance signaled that they had *not* been assaulted. In

my own case, imagine being in one room investing yourself physically, mentally, and emotionally in trying to keep a patient alive, then walking out of that room and immediately into another and directly into the fist of the relative of the patient who was unhappy with the timing of care. Now imagine that this was reported to the authorities and to organizational leadership, with the question of leadership being "what could you have done to prevent this from happening", and law enforcement stating that since the incident was not recorded that it was merely one person's word against another's so there was nothing that could be successfully prosecuted.

In another role, imagine that law enforcement requested EMS evaluation and transport for a patient who had been acting aggressively and was believed to be suffering from a medical condition, whether psychotic in nature or illicit drug induced. While attempting the evaluation, the patient becomes violent and kicks, punches, or bites you, but due to the fact that the patient was under the influence of mind-altering substances or suffering from some sort of mind-altering medical malady, prosecution is deemed to be nonviable and therefore not even attempted. How many situations in either role would the average person have to endure before they said enough was enough and left the profession-especially in a minimum wage position? Yet the response from the public to such complaints is often, "that's what you signed up for". And yes, that is a verbatim response that I personally received.

Early in the pandemic, healthcare workers were revered, but that very quickly deteriorated. As the fears grew, healthcare workers found it increasingly difficult to go out in public while in uniform; some were physically assaulted, others were ostracized and verbally accosted, even though the uniform may not have yet made it in to work. Already an alarming issue that was on the rise prior to the pandemic, since that point the abuse has escalated further[25, 26].

It is also noteworthy that threats against staff also have an impact upon healthcare professionals' turnover and retention. I have also been personal witness to the mother of a physician who threatened the jobs of the entire ER staff if she was not rushed to the front of the treatment line, as well as a similar experience with a board member who was at the bedside of a parent. Incidentally, it is also a not uncommon practice for hospital leadership to add an additional staff member whose sole purpose is to be ready for any potential need of an organizational donor, board member, politically important patient, or other VIP. Not only does this contribute to the frustration of staff, but also gives false reassurance to individuals in leadership positions that situations are not as dire as other patients or staff report.

Section Conclusion

Rural residents have historically had trouble obtaining medical care. From lack of available resources, to specialty turnover, to supply chain disruptions, to distance to care, to cost of seeking care, rural residents are at a tremendous disadvantage compared to more urban patients. Healthcare organizations face increasing pressure to perform while also are being

reimbursed less for the care provided, leading to sales or closure of hospitals. Staffing also is an increasing issue, with long-term causes being increasing burnout as a result of increasing workloads and pressure to perform and/or insufficient wages.

Proposed Mitigation

Pointing out problems, whether real or perceived, is easy. However, in order to address concerns, those in positions of power and authority must have the issue defined and the implications drawn in order to weigh the risks and benefits to all involved parties prior to effecting change. To that note, individuals who only point to problems without offering solutions are merely complainers. Following are potential mitigation strategies to address the concerns I have raised.

Insurance

Insurance, due to its ubiquitous presence throughout the business world, is one of the most difficult to manage. Too much regulation, and capital is unable to be recouped. However, it is apparent that insuring companies have reached the point where they require additional regulation.

As previously stated, expenditures by insurers is down about 2% since the enactment of the ACA and more than 15% since transitioning from private nonprofit entities to the current publicly traded, for profit model around 1994. Additionally, with premiums and deductibles steadily on the rise concurrently with healthcare costs continuing to increase, the patient has suffered a double whammy and indicates that the ACA has not performed to expectations. Combining that with the new practice of purchasing interest in healthcare organizations, and the situation is ripe for abuse.

One of the first things that must be done is prohibition of this practice. Insurers will likely argue that there is little to no difference between what they are doing and the old practice of a hospital offering their staff insurance, but the old practice occurred when hospitals and insurance were primarily non-profit. In addition, hospitals guaranteeing payment of medical bills in their facilities by staff was a perk of employment not offered to the general public at the time.

The other argument that will likely arise is the similarity of UPMC and Geisinger hospitals and UPMC and Geisinger insurance. In both cases, the healthcare organizations and the insurances are completely separate, nonprofit entities rather than the publicly traded organizations of such insurers as United Healthcare, Anthem/Blue Cross, Aetna, and others that

are currently purchasing interests. UPMC and Geisinger, along with other medical education institution insurers, had their insurance offerings developed separate from their respective healthcare delivery organizations[27]. Due to the separation of the insurance from the healthcare entity and the nonprofit status dictating that only a portion of excess income be able to be held over from year to year without being reinvested, there is a much lower concern for abuse regarding raising premiums while simultaneously inflating delivery costs.

For those insurers that have already purchased interests in healthcare delivery organizations, a stipulation should be added that moving forward both the delivery organization and the insuring entity be subjected to regular audits not only to promote transparency regarding pricing and reimbursement, but also for comparison to other organizations' practices to monitor trends and prevent abuse.

Secondly, a hard look should be given to the 80% minimum limit on loss ratios. The reason that insurers went to primarily being publicly traded entities in the mid 1990s was the fact that they were unable to keep up with the rising medical costs associated with a shift from disease mitigation to disease prevention. However, once the focus shifted from patient support to pleasing shareholders, the cost of medical insurance began to skyrocket. Since the transition to for profit, publicly traded businesses, and especially since the enactment of the ACA, health insurance until the beginning of the COVID pandemic was one of the most profitable business models in the United States. While it can easily be recognized that the 95% loss ratio was not sustainable, 80% seems too liberal. I would propose an 87% loss ratio requirement, enacted incrementally and the impact reviewed annually, with stop measures in place to prevent inordinate loss on the part of the insurer should it become apparent that an 87% loss ratio is not feasible. Obviously, this will receive severe pushback on the part of the insurers, but also will ensure transparency on their end through the recent enactment of the No Surprises Act (NSA) signed into law by President Biden. Comparing medical billing charges through the NSA to the loss ratio figures, a balance that works out in the favor of the patient with lower impact to the healthcare organizations and the insurers should be the overall effect.

An additional concern regarding insurance corporations using employees only experienced or qualified in medical coding and billing denying payment for prescriptions, tests, or procedures ordered by advanced practice personnel and physicians would be the addition of a regulation that requires insurance agencies of all types operating in the Commonwealth of Pennsylvania to have an additional education requirement prior to working. These denials result in additional pressure and time away from patient care to ensure that the patients are receiving the appropriate diagnostic functions and treatments, as well as contributes to job dissatisfaction, burnout, and turnover. The education in this regard would be full college courses in applicable topics, such as (but not limited to) Pathology and Physiology, Pharmacology, Microbiology, and Principles in Patient Care.

Regarding Medicaid reimbursements, which are primarily in the control of the states rather than the Federal Government, the Commonwealth of Pennsylvania should consider

returning more to the previous practice of offering a pathway to 100% reimbursement to hospitals and situated in locations dense with CMS patients. While not entirely making up for the shortfall caused by the ACA upon these hospitals, mitigation of the decrease in revenue would assist in these hospitals and having funding available for buildings improvements, increased offerings of care, and equipment acquisition. Additionally, EMS agencies based in these areas should also be guaranteed CMS reimbursements congruent to the actual costs involved in providing and transporting the patient, rather than a simple mileage calculation (more on that later).

Healthcare Organizations

At this point, affordability concerns regarding healthcare delivery will have to wait until full implementation of the 2022 No Surprises Act. While there are provisions contained therein that I support, I did not and do not support the bill as currently written. Too much pressure was placed on healthcare organizations without reciprocal protections being placed on insurance providers, nor upon patients seeking superfluous medical care.

With that being said, there are certain other practices to which healthcare organizations should be pressured to adhere. One of these is regular financial practice and staffing practice audits performed by multidisciplinary healthcare profession inspectors. While not primarily punitive in nature, the purpose of these audits would serve two primary goals. The first would be transparency regarding financial and staff utilization, the second would be development of best practices to be offered for implementation by healthcare organizations in underserved areas struggling to maintain services. The ACA model of reimbursement gave financial incentive to perform better and allows a pathway for chronically failing hospitals to fail, but there was no regard to safety net hospitals to remain solvent. In the event of mishandling of financials, additional fines could be developed from those already in place to cover the costs associated with the audits, as well as for limited support of struggling institutions.

As a protection for rural residents requiring medical care, healthcare organizations should be required to show definite cause for ceasing facilities or specialty care services. The pandemic has shown that decreased specialty care offerings have a downstream affect on larger centers, in that once smaller facilities have been inundated with patients requiring care, additional patients must then be shunted to larger centers who also would be receiving additional patients from other hospitals. PHS and UAHS in particular failed the rural communities they serve, in that the parent hospitals were ill equipped to handle even an influenza surge, let alone such an influx of patients requiring the advanced care that many COVID patients need. In regards to inpatient specialties, permanent closure of units and access to specialties should be strictly prohibited except for a well delineated, temporary situation. Should care offering be ceased for any reason other than those yet to be determined acceptable parameters, or should they exceed the temporary deadline parameters without additional and permissible justification, fines should be developed commensurate with the impact upon the local communities. Should the impact be prolonged enough or at a critical

time that the organization feels pressured to sell, the requirement that sufficient time be allowed and first opportunity given to staff members of the organization rather than to a larger organization for the purchase of facilities and supplies. This will aid in ensuring that the organization keeps the needs of the community as a primary goal, rather than any goals of larger institutions and would be in keeping with the "competition is better" principles of business upon which the nation has succeeded.

Additionally, healthcare delivery organizations (namely acute care hospitals, free standing emergency departments, outpatient clinics, long term rehabilitation centers, and other organizations dependent upon registered nurses, licensed practical nurses, and nurses aids) develop specific billing parameters for the care which this group of caregivers provides. Efforts to do so have thus far been unsuccessful, but with legislative incentive and pressure, healthcare delivery organizations would be better able to accurately charge for care rendered rather than relying upon inflated prices of other services or supplies-typically wrapped up in "facilities fees". One of the primary means of doing so would be to work off from the Full Time Employee (FTE) scoring and Hours Per Patient Day requirements that nursing leadership use to calculate for the number of staff needed when creating staffing schedules[28]. This should then be translated via backend billing processing to create new Revenue Generating Units (RGUs) for more appropriate and transparent fee structures.

Finally in regards to healthcare organizations, ownership of mishaps in the face of staff complaints should be primarily absorbed by the organization, rather than the organization attempt to fire the staff members who pushed for changes that were denied by the organization and a mishap or error occurring. Prior to punitive measures being enacted against an employee, upon notification that measures are being enacted there should be a review panel within the Commonwealth to which employees can address such issues. The employee would either be subject to temporary time off duty but paid by the organization without impacting accrued time off, be permitted to work at a reduced capacity (non-direct care role) by the organization, or be permitted to use accrued time off should the organization permit the employee to remain in their role. The process would ensure that as employees currently have access to email accounts and internal organizational documents removed upon termination, access to all documentation, emails, and supporting evidence be readily available rather than have to be discovered through legal channels at the expense of the employee.

The panel should consist equally of staff member-level individuals and executive level individuals, plus an outside, third party non-healthcare individual that would create a simple majority decision, and should be comprised of people free from interest in the organization and employee(s) in question. The panel would be supported through the levy of fines, should have investigative authority, and should have enforcement authority. If the panel finds in support of the employee(s), the healthcare organization would be subject to reimbursement to the Commonwealth the time spent by the panel hearing and investigating the concern; be subject to a safety audit by the appropriate Commonwealth organizations; and reimburse the

appropriate organizations for the cost of the audit along with implement changes directed by the appropriate organizations. In the event that the panel finds in support of the healthcare organization, the employee(s) will be subject to reimbursement of the Commonwealth for the cost of convening the panel and subsequent investigation, as well as be subject to immediate enactment of a restriction upon the employee's license or certificate to work in healthcare. Such a design will minimize the impact upon the Commonwealth, as well as provide onus upon both parties to act in good faith in support of their respective positions. Panels should be convened no longer than 1 month after report of the employee to the Commonwealth in order to minimize either time spent away from work or to expeditiously remove an unsafe employee from the healthcare field.

It will be argued that typically protection of workers is typically a union responsibility, but healthcare workers' unions have been proven to be especially inept at protecting their members and effecting necessary safety changes in the healthcare environment.

Healthcare Workers

As has been demonstrated during the ongoing COVID pandemic, staff level healthcare workers are essential to public health. I have previously described how staffing levels are at and will continue to be in a crisis situation for the foreseeable future. This results in a complex quandary: how to attract and retain staff-level individuals without compromising on patient care and safety.

One measure to retaining healthcare workers would be through removal of property taxes. In these descriptions, the term "healthcare workers" should be applied to all staff-level employees, from EMT-Basics and Certified Nurse's Aids, to Licensed Practical Nurses, to paramedics and staff Registered Nurses, to Physicians Assistants and staff-level (as opposed to administrative or education) Nurse Practitioners, to staff physicians and surgeons (as opposed to those functioning primarily in an administrative role). While not typically a member of the "taxation is theft" crowd, the single point at which I agree is on property taxes. Essentially, a property tax is the government saying "congratulations on renting from us; fail to pay and lose your investment". While I personally believe that abolition of the property tax should be extended to everyone, removal of this tax for staff level healthcare workers would be an incentive to this essential demographic to either join or remain in healthcare. It would also serve as an enticement for these workers to be personally invested not only in their professional role, but also in their communities, and potentially serve to attract new talent to the Commonwealth.

Another enticement would be that the Commonwealth actively seek the input of active staff-level healthcare professionals when considering legislative changes. Contact information for these individuals is readily available through the Commonwealth's Office of the Professions, and input could be sought through random selection from the lists. Not only would healthcare

employees feel that they have a voice in the bureaucratic decisions being made, but this would also serve to promote pride and advocacy in their respective positions. It would also make access to governmental decision making easier to achieve, and promote transparency within government workings. One case in point to this position was the sudden change of Registered Nursing licenses from every 2 years to annually back in 2020. Little notice was given, which had several of my colleagues scrambling to complete required continuing education offerings that had previously been delayed for a myriad of reasons including but not limited to expansion of families, starting a new career opportunity, moving of a residence, and illness; the change simply caught them at an inopportune time and without significant warning.

An additional enticement would be a clear pathway to full and autonomous practice within respective professions based on competency, rather than degree status or the whim of other entities. Physicians Assistants (PAs) and Nurse Practitioners (NPs) come immediately to mind, with Nurse Practitioners at the forefront. Currently, Pennsylvania requires Nurse Practitioners to have oversight from an attending physician. However, other states have significantly permitted autonomous operating by NPs, without a statistically significant result in patient harm or dissatisfaction[29, 30]. Indeed, literature review shows that NP harm most commonly occurs during the first few years in practice in the new role, following Patricia Benner's "Novice to Expert Theory" of role attainment. Not only would creating a pathway that permits full autonomy promote rural practitioner retention, but also alleviate much of the strain on physicians to see and treat patients. In the same regard, removal of organizational barriers to full and autonomous practice of other staff members should be pursued.

An active safety effort must also be initiated to prevent overworking of healthcare professionals. There is a plethora of studies showing that even the addition of a single patient to a nurse's workload can significantly increase likelihood of patient death. It is almost to the point where nurses no longer ask "which of your loved ones has to die before something changes", because we know that the only answer we will receive will be the blame for the death. Previous attempts at safe staffing legislation in the Commonwealth have failed, and while I do not speculate on the cause of the legislation believe that workable solutions must be found. Failure to enact such legislation is placing staff under incredible undue stress over not being able to provide the level of care to which they are trained, let alone desire. It places patients at risk due to insufficient staffing leading to late and missed medications, missed alarms warning of impending patient danger, patients at risk for injury due to unwitnessed falls, and fatigue from overwork leading to missed drug interactions, wrong dosing errors, and other clinical harm up to and including death. The most effective means of passing this legislation, in my opinion, is that rather than staffing according to straight numbers would be to force staffing according to nursing hours per patient day in order to staff to acuity and not waste staff nor funds, combined with legislation that permits the use of new nursing revenue generating units for billing purposes.

I cannot begin to describe the number of times that I have walked into a hospital and had physicians refuse recommendations made by flight crews regarding the care of patients, even though the physician typically did not have a similar recent experience level with the criticality of many patients. I have watched physicians butcher intubations, fail to resuscitate patients using nationally recognized benchmarks, and perform procedures that they had only seen videos of whereas members of the flight crew not only had been thoroughly trained, but required to regularly practice to gain and maintain proficiency. True Rapid Sequence Intubation guidelines, in particular, call for the most experience care team member available perform the procedure, rather than delineating a particular role player to perform the function. Experienced staff members are forced to stand by and take orders from physicians and mid-level providers having the technical requirements to fulfill their roles, yet lacking in the skills and knowledge necessary to not only to be functional but also limit patient harm.

A final enticement to promoting rural healthcare access would be removal of barriers for direct-to-patient care by applicable providers. In a move signifying pushback by physicians against larger organizations, many have began offering consultations, care, prescribing, and testing outside of organizational offices in a slight return towards older, more traditional physician practice. Physicians and patients alike report increased satisfaction, lower operating overhead, and lower economic impact than in what is now traditional insurance-billed and organization-directed care model[31]. However, due to lost revenue by healthcare delivery organizations and perceived threats of possible medical malpractice, many physicians are actively discouraged and even threatened regarding such an endeavor.

Medical Specialties

Medical specialty care has been, and continues to be, one of the most difficult portions of rural medical care to access. Partly, this can be attributed to quantity of cases, especially in regards to those requiring advanced procedures rather than routine care. In regards to quality medicine, the trope "if you don't use it, you lose it" can especially hold true. That was one of the rationales for limiting the number of Level I and Level II Trauma Centers[32] in the Commonwealth. Due to the classification of large areas of Pennsylvania being designated as "ultra rural" by CMS, the volume of patients may not necessarily permit individual hospitals having their own unique specialists of each-or even most-varieties.

One means of accessing specialty care has been through the use of telemedicine, a practice that gained widespread traction during the course of the ongoing pandemic. Telemedicine allows not only direct conversation between a referring physician, a remote physician, as well as the patient and/or family, but also visual engagement through camera and viewing screen. However, access to specialties in this manner is limited by contractual issues, such as engaging in telemedicine for only neurological cases or only pediatric issues. It also limits organizations to specific other organizations, such as UPMC Cole to UPMC Childrens Hospital of Pittsburgh. Tentatively, the NSA would prohibit balance billing of organizations to patients for going outside of these agreements by contacting other centers through which the

patient and/or patient's insurance may have an affiliation, but there is the question of whether the programming of telemedicine units would allow for this attempt. Attention should be paid and efforts made to support-at the organizational and state level-increasing the use of this technology, especially for patients who are of lower acuity and/or for ongoing outpatient care.

Inpatient psychiatric care, on the other hand, is a desperately needed service that unfortunately may require direct state involvement. Some patients unfortunately are not able to be sufficiently managed outpatient, and yet there are not sufficient facilities available for their required ongoing safety and care. Additionally, there is a decided lack of beds even for acute psychiatric patients. I do not presume to even begin to have knowledge of the intricacies of ongoing inpatient or outpatient psychiatric care, but I can attest to the frustrations of both patients and staff when psychiatric patients are left in the lurch. It is my recommendation that a focus group of insurance providers, hospital administrators, legislators, psychiatrists, primary care physicians, and emergency physicians be convened to address the problem.

Emergency Medical Services/Interfacility Transports

As stated elsewhere, for EMS and transport systems the biggest concerns are staffing and funding. EMS pays at significantly lower rates for staff when compared to similar staff positions in healthcare, yet operates at a higher rate of assault, physical and chemical hazards, and longer shift durations than their office and acute care counterparts.

One type of assistance that can be readily provided through the state is reimbursement of actual costs associated with the transport of Medicare patients, on top of or in lieu of the mileage fee structure. While still not paying for the staff, such a reimbursement system would still be more advantageous than merely paying on a fee structure based entirely off from transport mileage. As the reimbursements currently stand, you get charged the exact same if I simply perform cardiac monitoring throughout my transport as if I use every tool and medication at my disposal. Although this has been partially attempted in the past, updates in technology and documentation platforms would at least make a feasibility study worth pursuing.

Additionally, at least for rural and medically underserved agencies, there needs to be some form of tax base to better allow EMS agencies to better stabilize their financial standing within the Emergency Response framework similar to fire and police departments. Currently, Pennsylvania statutes require that communities provide for ambulance transport for citizens, but the statute is left open ended in regards to just *how* the communities meet that criteria. Having an underlying, steady, tax-based income upon which to not only hire but to pay staff at a rate which would promote retention would greatly assist in managing turnover.

A contribution at the state level would be subjecting EMS agencies to regular audits for the purposes of forming best practices. While intrusive, information sharing and trends would better assist non-profit agencies to at least maintain viability, when many for-profit agencies are able to provide the same service at a fair cost and not only maintain their employee base,

but also improve facilities and equipment. (It should be noted that at each point in this discussion, "best practices" should be recommendations rather than requirements due to the variable nature of the healthcare landscape.) While proprietary information would not be required for disclosure, fee structures and savings plans have the potential to alter failing business models and better stabilize organizations. This would also serve to rein in some of the higher charging services. One patient I had while pulling an ER shift was refusing to fly because he couldn't imagine what the bill would be after having received a 911 response bill of over $19,000 from Priority Care EMS out of Smethport, PA. When I described to him that that type of charge would be more in line with the HEMS billing, he was as shocked as I had been upon hearing the ground ambulance charge.

Another state-level contribution would be reversal of rural EMS cooperatives being merged with their more urban counterparts. Having been involved in both settings, I can say better than most that what works in an urban environment will not necessarily work (and often doesn't) when considering extremely long response times and distances, as well as long transport times and distances. As an example, "Treating on the X" works great when there is sufficiently responding staff from ancillary agencies with additional similar roles, equipment, and medications. But for a rural practitioner, "Treating on the X"-performing initial stabilization of patients prior to extrication from encountered location to the ambulance-can exhaust staff and supplies in rapid succession, leaving the ambulance crew unable to continue management the rest of the way to the hospital. Such concerns were drowned out in the adoption of the policy due to the forced mergers.

Yet another state-level endeavor worthy of inclusion would be a push for Community Paramedicine. This is a fairly recent development designed originally for rural communities, but has unfortunately been more easily adopted into urbanized locations. One of the reasons for this is that Pennsylvania seemingly has a requirement that Community Paramedicine start ups be directed through teaching hospitals; please find me a teaching hospital in sufficient location to Kushequa or Renovo, Pennsylvania to provide effective Community Paramedicine guidance. What Community Paramedicine does is a qualified agency responds to a 911 dispatch. Upon arrival, the paramedic determines if the patient first is acutely ill and definitely needing transport to Emergency Department testing and care, or if the patient is of lower acuity **AND** is willing to accept a telemedicine conference with a hospital capable of providing Community Paramedicine direction. If the patient is not willing, then they are transported to the ER like any other 911 dispatch. On the other hand, if the patient of lower acuity **AND** is willing to accept a community paramedicine consult, the paramedic initiates a telemedicine call with the Command Hospital, reports on the patient, and a discussion is engaged in the best course of action for treating the patient's malady. If it is ultimately determined that the patient needs additional care, the Command Physician can provide appropriate immediate orders to the paramedic, then provide outpatient prescriptions and testing orders, then contact the patient's primary care office to relay what was done. This serves to improve the immediacy of care to many patients, decrease unnecessary Emergency Department visits, improve satisfaction of

physicians, paramedics, and patients, and provide an additional source of income for the EMS agency.

One educational way in which Pennsylvania could contribute not only to rural EMS systems via improving quality of care and expansion of services, but also formal recognition of prehospital professionals would be adding a Bureau of EMS approved Critical Care Course to the offerings of the Northern Pennsylvania Regional College. Allowing Paramedics, and the occasional Registered Nurse, the opportunity to earn both college credits and EMS continuing education credits would serve as an enticement for rural practitioners to achieve a higher level of practice, rather than forcing them to travel considerable distances and spend days to weeks away from their families in order to acquire the additional skills possible.

Also, due to the weather patterns especially in Northwestern Pennsylvania, additional critical care ground interfacility transport resources are needed far more than air medical critical care resources. Lending itself to the efforts as well would be a stratification of critical care ground resources, better following the NHTSA designations of "stable with a slight chance of decompensation" that would permit ground medics to perform many transports. With additional training, paramedics can easily be taking some of the more stable critical care patients, such as those only on a single vasopressor, those receiving insulin, those that have had blood products initiated, those receiving CPAP or BiPAP regardless of adjustment changes, and stabilized ventilator settings. On top of that would be the more common (to Pennsylvania) pairing of a medic with a nurse for the more "stable with a high chance of deterioration" description within the NHTSA Guide for Interfacility Transports[33].

As the situation currently stands, many EMS professionals-especially those working multiple jobs or at extremely short staff agencies-quickly burn out. Education opportunities for these individuals require a significant investment, not only of money but time. Imagine being an EMT-B, knowing that if you don't pick up the next shift in succession that assistance for your community may require a response not from the next jurisdiction, but the next state. Or knowing that if you don't pick up the next shift, you won't be able to afford the doctor's appointment your child has coming up, and also knowing that your agency doesn't have the financial resources to provide you with a wage increase. Now imagine that you're going through school for a healthcare related field, but due to the hours you're working you're unable to meet deadlines or put in adequate amounts of time studying to pass exams. All of the time you've invested likely made you a better provider, but if you can't pass the exams and meet assignment deadlines you're going to fail the courses and either have to repeat them at additional time and financial expense or just give up entirely. As an anecdote, I have worked for Port Area Ambulance Service for about 10 years now, and as a Registered Nurse am only making around $14 per hour (comparable to the medics); EMT-Bs that have worked there for decades are making around $9 per hour. Due to lack of ALS level staff, I have been pulling multiple shifts each week for the last 6 months in order to provide consistent ALS coverage, causing my work weeks to generally be in the 96 hour range-the equivalent of 2 full time jobs

with over time at each. For comparison to that wage, I was earning $35 dollars when I left hospital nursing, and am currently making around $33 at my present HEMS job. This $14/hour figure is sadly far from commensurate with skill levels, knowledge, and years of service of medics working in similar organizations for similar pay.

A final state-level contribution to EMS staffing stability would be transitioning from hours-based continuing education, to a more competency-based format for certain certification levels. As an example, the EMT-B is an extremely valuable part of the EMS team, but extremely limited in the scope that they are permitted to perform. Because of that, although knowledge of functions outside their scope of practice and additional background knowledge of medical maladies is frequently beneficial, it typically does not contribute to overall quality of care provided due to the limitations placed upon them. Obviously, changes to their scope of practice, changes in laws, and other pertinent information should be required on an hourly basis, but since the functional role is largely unchanged within the Commonwealth over the last several decades, the addition of more continuing education has proven to drive more EMT-Bs from the role than contributed to the overall care. Is it worth having a requirement for knowledge, when there is no one actively working in the role? Perhaps more applicably, is it worth having an EMT incapable of more than applying oxygen, administering certain pre-prescribed medications, placing more than a basic airway, or splinting and bandaging yet capable of describing in-depth arterial blood gas results?

Drug Shortages/Group Purchasing Organizations

Due to the chronic compounding effects of real and pseudo-shortages of drugs and supplies, attention must be paid to the subject. Lack of availability leads to bidding wars, for which rural areas are ill equipped. When combined with lack of means of transport to other organizations, this leads to additional limitations on the access of rural residents to healthcare.

One means to combat acute and chronic drug shortages would be through the creation of a state wide acute care drug inventory. Unfortunately, this would be a very sizeable initial investment on the part of the Commonwealth, but would help to ensure critical drug availability during shortages. An appointed member by the Commonwealth would be tasked with monitoring the FDA Drug Shortages List for a period of 1 year while funding is raised. At the end of that year, drugs that have repeatedly or for prolonged periods but are in common use would be purchased and stockpiled against future shortages. These purchases would occur once the drugs are more readily available, and would encourage pharmaceutical companies to both continue production due to a known and stable market, as well as to discourage false shortages either through intentional manufacturing lags or through inordinately large sales to a single-point supplier organization. These drugs would be stockpiled through "high points" of the manufacturing stage, and when shortages begin to occur for the myriad of possible reasons, healthcare delivery organizations and EMS agencies would have an option for acquiring these medications. The three most difficult aspects of managing the stockpile would be obtaining the initial funding needed, monitoring turnover to ensure product availability within the useful

dates of the drug, monitoring the supply chain issues to ensure that the stockpiled drugs are not released too soon, and that cessation of the supply from the stockpile does not end too late. This last part is important, because manufacturers need sufficient sales prices to continue manufacturing, which is one of the causes for waxing and waning availability[34]. Continued viability of the stockpile would be achieved through sale of the shortage drugs at the going market price at the time of the shortage, not at the initial purchase price by the stockpile. It should also be noted that the stockpile only be comprised of those medications essential to the acute care of patients (such as norepinephrine, epinephrine, commonly used IV antibiotics, commonly used IV sedatives, and similar medications), rather than all possible or commonly short medications.

Obviously, there will be significant pushback on such an endeavor. Public detractors will decry such an action as a move towards socialized medicine, similar to the way the National Strategic Stockpile was protested during its inception. Also, healthcare delivery organizations and group purchasing organizations will cause problems. Healthcare delivery organizations must be engaged early in the process to reassure them that the stockpile will be there during times of shortage to ensure a more consistent supply chain, due to the fact that there will likely be a sudden surge in price and secondary slight decrease in overall availability once buying actually begins (and subsequent to development, resumes after supply chains catch up). Early engagement will also be for the purposes of education regarding exactly when the stockpile will be available for resupply of medications, rather than simply being an alternative purchase point. GPOs will also need to be engaged early to ensure them that the stockpile is not meant to be a competitor to their organizations, but again merely a buffer against lack of state-wide availability. It should also be noted that there is currently no similar stockpile of these types of medications globally, and that the legislature begin to be prepared for these concerns. The resultant market would end up looking like a prolonged period of "ramping up" of availability, a period of wide-spread availability, and a prolonged period of decreased availability; this would be a contrast to the more frequent and sharper ups and downs of current availability fluctuations.

Group Purchasing Organizations must also be addressed through legislative efforts. While some are still operating in good faith, some intentionally create pseudo-shortages through the use of sole-purchaser and/or sole-supplier contracts, and intentionally play to localized market highs and lows. The use of sole-supplier contracts should be halted via legislation, both for supply chain stability as well as improving the financial stability of EMS agencies and healthcare delivery organizations. When shortages do occur, as they inevitably do, healthcare delivery organizations should not be penalized via contractual obligations when the GPO fails to meet the supply needs of the healthcare delivery organization and the healthcare organization accordingly procures the needed supplies elsewhere. This is an intentional harm against the financial stability of essential healthcare delivery organizations, especially in medically underserved localities.

General Public

The general public also contributes to rising costs; delayed access to care; caregiver job dissatisfaction, burnout, and turnover; and worsening personal and public health concerns. Some of this is unknowing, some willful self-neglect, and some intentional interpersonal violence.

One of the things that has become apparent as the current pandemic has progressed is the need for a prolonged, interdisciplinary, interorganizational, bipartisan, and multi-platform education campaign. It should feature individuals from all walks of life and spanning all professions, politicians of both parties, could involve leadership from multiple healthcare delivery organizations in the same ad, and be offered across social media platforms, newspapers, website advertisements, and television and radio ads. The content of the message should primarily be appropriate utilization of available healthcare opportunities and teachings. This would improve public knowledge of availability and importance of medical screenings, access points to healthcare and appropriate utilization of those access points (i.e. primary care compared to urgent care compared to emergency department care compared to ambulance utilization).

An additional area of concern, as previously stated, would be that of violence against caregivers. A state wide no tolerance approach is imperative. Thresholds for prosecution should be lowered for this offence due to the extremely common nature. Additionally, protections should be enacted for those caregivers who defend themselves. Currently, particularly in the cases of patients, even if one is acting violently against staff the staff can be held liable for injuries sustained by the patient in preventing the patient from harming staff. No other profession is held to this extreme of a standard, including law enforcement. Additionally, there should be a well-known means of reporting violence against caregivers, especially in situations where healthcare organizational leadership has decided to cover up the situation, and healthcare organizations held accountable for those actions. Enactment of additional zero tolerance legislation, expansion of existing legislation within the Commonwealth, and increased enforcement of new and existing statutes would have a morale boosting effect on healthcare professionals that would contribute to overall retention and safety. These efforts could also be worked in to other media ads in an effort to spread awareness of not only the issue, but the implications of engaging in these behaviors.

Finally, general population education must be provided regarding end of life care. Many detractors will say that this is a step towards removing all care for individuals based on age, but I personally lean towards protecting meaningful years of life and death with dignity. Patients that have no quality of life due to being bedridden, with extremely limited cognitive function, and combined with extremely slight medical chance of recovery, should not be forced to undergo extremes of care especially when being transported hours away from loved ones. This not only frustrates caregiving staff, due to having to watch patients pass without family at the patient's side, but adds to financial impact upon overall healthcare costs. I have been the

responding ambulance staff, transporting HEMS crew, and interim ER nurse for countless of these patients. These patients are often bent and contractured due to having been bedbound for years, and typically have poor cognitive abilities due to end stage Alzheimer's, dementia, Parkinson's, or extreme stroke. They are ripped from their beds and taken out into the heat, cold, rain, and snow by strangers who then probe their sore and worn out bodies, stab them with needles to administer medications and draw blood, have tubes put into orifices, are stripped naked for exams in front of countless strangers, and often are sent on to larger hospitals where all of this is repeated all over again. This is not to say that patients should be permitted to suffer their way to death, but rather when in end of life situations that have statistically hopeless outcomes arise, the patient should be kept warm and comfortable in the surroundings to which they have become accustomed until the same end that meets us all arrives for them.

Instead of this, a staff member calls the patient's loved ones, whom almost always have poor medical understanding of the situation and then request medical evaluation, leading to the cascade described. In rare occasions, it is actually a member of the emergency healthcare team that offers the false hope that transport to another medical center *may* have a chance at prolonging the patient's life at or around the same functional level. Improved education of the impact upon patients, staff, and family would help to alleviate this practice and allow a much more comfortable, much more dignified passing at the end of life.

Conclusion

While I apologize for taking so much of your time, I appreciate your indulging me on bringing to light several of the issues with which I have engaged during my work in emergency care of the ill and injured. The instances that I have described have been limited only to those with which I either was a participant, or those related to me by individuals I trust and know personally. I could tell countless other stories of being on the ambulance and responding to an accident scene and lacking additional qualified staff to assist in performing stabilization while en route to a hospital due to helicopters not being able to fly; of being the bedside nurse with an actively dying patient, knowing that if air medical or closer critical care ground transport were available the patient would not only survive, but survive with a meaningful life; of spending hours at a bedside arguing with physicians over delivery of effective care; of being so busy in the aircraft with a critical patient that the pilot was forced to deliver our prehospital notifications; of the hunger of rural nurses for quality, affordable, and hands-on continuing education and medical care closer to home; of nursing staff knowing the best course of action yet being overridden by family or physicians; of physicians knowing the futility of actions yet being forced by remote family members to provide meaningless and expensive care; of many more patient misadventures caused by unsafe staffing; and the stories of patients who spent

hours next to me in an ambulance describing how they knew the self-care they needed to perform but were unable due to expenses or access issues. Even a modicum of effort in engaging staff-level healthcare personnel would yield many, many more first hand accounts.

My loyalty extends not to institutions or organizations, but instead to the patients and staff with whom I work on a daily basis. For the last 10 years I have worked full time at one healthcare job, and pulled part time hours at others, in other roles. This has let me see the impact at various levels I have described in a way that even most within the healthcare professions do not get to see.

Under normal conditions, discussions such as this would require sacrifices on the part of all involved, but I have to ask: what more could be expected of staff? Travel positions have shown just what organizations are willing to pay for staff, and even in those situations where pay rates are similar it was revealed that staff was better off doing their own retirement investing and purchasing their own insurance than was being provided, and without the headache of contractual obligations to organizations. Staff is already exposed to hazardous working conditions-both physically through assault, passing vehicles, and haz-mat situations, as well as to their health through overwork, stress, and being exposed to various illnesses. Frankly, healthcare staff has given everything they have to offer and are through being taken advantage, as is demonstrated by staff leaving healthcare altogether in the hundreds of thousands per month. So in this case, it would seem that healthcare staff have nothing left to give, and it will take extreme measures on the parts of all the other stakeholders to keep healthcare afloat.

I have done my best at explaining just a portion of these situations, but am far from having the most in-depth knowledge of many-even most-of the problems. There are many far more qualified and knowledgeable about these intricacies, but many of those are also personally invested in whichever side of the slate they are employed. While those individuals would better suited to explain organization-specific impacts, I would encourage those of you in positions of authority to instead focus more primarily on those of us who are actually and deeply invested at the bottom of the pile, being cared for and caring. By doing so, not only are the homeless, addicted, and societally rejected cared for-*truly* cared for, but also the CEOs, the investors, and the guarantors.

Once again, thank you for your time, interest, and efforts.

Chris Benson

BSN, PHRN, CEN, TCRN, CFRN

Quick Look

Insurance	
Insurance transitioned from non-profit, 95% loss ratio to for-profit, investor driven 82% loss ratio since 1993 and continue to mitigate payouts lower	Incrementally and with stop measures adjust loss ratio from 80% to ~87.5%
Prescribers have orders challenged by non-healthcare insurance employees	Ensure training of insurance employees to healthcare to mitigate insurance discrepancies with needed care
Insurance Companies purchasing hospitals, physicians practices	Prohibition of practice
CMS no longer reimburses 110% of care provided to rural hospitals	Medicaid payouts to 100% reimbursement to hospitals
EMS services not reimbursed to cost of care	Transition to amount of care based-service rather than simply loaded mileage

Healthcare Delivery Organizations	
Rural hospitals closed at higher rates after passage of ACA, are still at significant risk of closure despite being bought by larger organizations	Regular financial audits by state inspectors would develop best practices that could then be provided to at-risk hospitals for implementation
Unsafe staffing leads to poor patient outcomes and decreased reimbursement	Auditing more successful hospitals by state inspectors would develop best practices that could then be provided to at-risk hospitals for implementation
Closure of units and removal of specialty care offerings places increased burden and risk upon patients	Implementation of broad use telemedicine would improve access to specialty care and improve patient access
Healthcare organizations not currently billing for nursing care provided	Development of specific billing through the use of nursing care RGUs would improve pricing transparency and improve revenue generation
Inpatient psychiatric care at crisis point	Requires state focus group to develop better access and increase facilities availability
Many healthcare organizations first try to push liability for patient mishaps down to staff level rather than take "Just Culture" approach	Implementation of state run safety resolution panel would force attention to needed safety concerns.

Healthcare Staff	
Staff members leaving positions in record numbers	• Removal of property tax requirements for all healthcare staff members • Promote independent practice and autonomy to full scope of practice • Removal of barriers for direct patient care practices • Ensure safety of staff members via safe staffing legislation, zero tolerance legislation, and zero tolerance prosecutions
Healthcare staff feel they have very little voice in bureaucratic decision making processes	Actively seek input by contacting healthcare professionals using Offices of Professions contact information

EMS/Interfacility	
Staffing Crisis	• Means of improving wages • Means of promoting job safety through zero tolerance prosecution and additional legislation • Switch from hours-based continuing education to competency-based proficiency requirements for some providers • Insufficient staff to perform interfacility transports and ground critical care transports
Financial Crisis	• Tax basis to in medically underserved areas to promote financial stability • Change Medicaid reimbursements to reflect actual care provided rather than straight mileage
Loss of voice in treatment protocols and bureaucratic decision making processes	• Reversal of rural EMS regional mergers with more urban regions • Contact staff when making policy and protocol decisions using Office of Professions contact information

Drug Shortages/Group Purchasing Organizations	
• Shortages of essential drugs cause increased financial impact on EMS agencies and healthcare delivery organizations • Shortages of essential drugs cause extensions of expiration dates and use of alternative, less ideal medications	Creation of Commonwealth drug stockpile to buffer against shortages and mitigate market fluctuations
Group purchasing organizations create pseudomonopolies through sole supplier, sole purchaser contracts	Prohibition of practice
Group purchasing organizations penalize contracted hospitals/agencies when GPO fails to ensure adequate supply	Prohibition of practice

General Public	
Regularly demonstrates no understanding of healthcare access point utilization	Multidimensional, multimedia ad campaign for public education on healthcare service utilization
Physical assault, mental, and emotional abuse against healthcare workers common place	• Enactment and prosecution of zero tolerance laws • Healthcare organizations held responsible for suppressing reports of violence against staff
Lack of knowledge regarding intricacies of end of life care	Multimedia ad campaign for public education regarding cost of services, effects on healthcare workers, effects on patients, effects on system

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January 17, 2022

Pennsylvania Committee on Rural Health

Dear Committee Members:

I have worked in the medical field most of my life in office capacity. I came to this area, McKean County, with my late husband, Douglas F. Bowman, M.D., through the U.S. Public Health Service. My late husband had a two-year obligation to fulfill. He was assigned to Misty Valley Health Center, Smethport, PA., a medically underserved rural area. He spent his entire medical career serving the people of McKean and Potter Counties. We came from suburban Baltimore to rural Smethport and stayed.

Over the years medical practices have changed dramatically with the majority of physicians being employed. Few doctors own their practices. Nurse practitioners and physician assistants are popular medical providers. Medical insurance rules change constantly under government control.

Recruitment to rural areas is very difficult. Most physicians and their families prefer an urban or suburban environment for educational, social, and diverse activities. We have all that, but most people do not become aware they exist, but on a much smaller scale. People do not realize we can drive to Buffalo in approximately two hours, which is the same time it may take you to drive across town in a large city. Towns and universities in the area offer many cultural events. Rural living has many advantages. During recruitment, all that is available in an area must be brought to the attention of the potential new medical personnel

Years ago, many refugees and displaced persons were brought to the US by civic and religious organizations. With the shortage of medical persons currently in rural America, it may be time to open that venue again. It may be possible to go to our borders or other nations and offer medical persons a position in rural Pennsylvania. A quick path to citizenship, a worthy job, a place they can buy or

rent a home with the guarantee that they live and work in that community for a minimum of five year, may help resolve the rural health care problem. A firm, consistent contract must be put in place for this idea to work. Foreign medical workers must be placed in a training, testing program to assure that they have the proper credentials to work in our medical facilities. This should include nurses, technicians, physicians, aides, and all needed medical workers. With lawful government policy and medical guidance, this plan could work. It has been done in the past. The rules and regulations are in place. They just need to be updated for medical personnel to enter this country legally and to be given a job and fair wage. Guarantees from all parties need to be put in place.

Thank you. I hope this is of value.

Sincerely,

Barbara Bowman

Testimony

Pennsylvania House of Representatives
Majority Policy Committee hearing
Regarding the plight of rural healthcare
Bradford, Pennsylvania

January 19, 2022

Aris Gredzens, M.D.

Thank you to the committee members for allowing my presentation.

Background of presenter:

I am a local Bradford obstetrician/gynecologist recently retired, employed in Bradford, 2013-2019 with BRMC; employed by Universal Primary Care in an office-based position only, 2019-2021. I was previously in Washington State for 27 years in a single specialty four person private OB/Gyn clinic in a town with an approximately 100,000 patient draw.

Observations of local healthcare after having moved from a suburban healthcare environment to a rural healthcare environment:

Same patient population, a mixture of private insurers and Medicaid

Hospital with potential 200 bed capacity, underutilized

Aging physical plant

Hospital in debt

Aging physician population: ENT, General Surgery, Pediatrics, Psychiatry, Urology,

Minimal number of primary care providers

Inability of hospital or community to attract and retain physicians

Minimal number of specialty providers

LONG-TERM established subspecialty providers retiring and unable to be replaced by recruitment

Loss of ENT: retired

Loss of Orthopedic providers, 2: retired

Loss of Pediatrician: retired

Loss of Psychiatrists, 2: retired

Significant turnover of hospital-employed physician providers in OB/Gyn, short term retention

Decreased deliveries in BRMC leading to closing of Labor and Delivery in 2019 with subsequent loss of that skilled nursing knowledge

Closure of inpatient surgery (2021)

Decreased inpatient beds for hospital admissions (now said to be 10 inpatient beds)

Over-utilization of ER by patients

Loss of anesthesia providers with closing of surgery

Contracting of radiology to out of town radiology group, physicians assigned to rotating through

Contracting of ER physicians to out of town group, physicians assigned to rotating through

Substitution of MD/DO providers (not able to hire/replace) by default by mid-level providers

Minimal dental care in the community for the indigent

Decreased ability to take care of emergency patients in-hospital requiring patient transport by ambulance or helicopter

Limited funding for ambulance services

Geographic(winding, slow rural highways), financial(insurance coverage across state lines), and weather (winter ice, fog) difficulties to transfer (even before Covid-19)

If these observations are typical of other rural hospital systems, one can see how rural health care systems fail:

Aging private practices unable to sustain themselves secondary to increasing economic costs of private practices; difficulties in recruiting new partners(due to increasing costs of hiring new physicians as employees, decreasing reimbursement, increasing expectations of new physicians for high salaries, need of new partners to have large salaries to pay off student debt)...all of this lead to hospitals trying to hire physicians as employees. Competition leads to either the hospital becoming more successful and private practices failing, unable to compete, or the hospital is unsuccessful and unable to continue recruitment and therefore the system deteriorates as private practices retire. Hospital systems taking on employed physicians leads to increased overhead straining the system. To save costs hospitals merge. Control of the local hospital system is lost; the local health care population feels powerless. If local populations decline, local industries leave, revenue streams for the hospital are unable to sustain health care and services decline. The hospital closes if merges are not able to save costs.

On a wider perspective, the State of Pennsylvania, the fifth most populated state, has an increasing elderly population. Health care costs are anticipated to rise. Demand for staffing for inpatient and outpatient services are anticipated to increase. Rural areas will be hard pressed to compete for these services; most providers(or their spouses)seem to favor suburban and urban settings for their families.

Physician financial expectations have become exorbitant. There is a bidding war for specialists, e.g. $300,000-400,000 for an obstetrician/gynecologist. (Many new practitioners have $200,000-$300,000 of school debt!). It is unlikely that smaller communities can meet these economic expectations and recruit physicians to their areas.

Both local and state-wide issues as outlined above leads me to the conclusion that health care cannot continue its present state of function in the rural community setting.

A new paradigm of health care in the rural community is needed. It is my belief that the smaller communities of the United States would be a place to start a new method of organizing health care providers and a health care system. It would be predicated on the need of the smaller communities to attract and retain health care professionals.

It is my proposal that the Commonwealth or the federal government offer to cover the full educational costs of health care providers in exchange for a required commitment of these persons to the rural community. This is not a new idea and is already done in the Public Health Service. I suggest to take it one step further: provide staffing of a FULL contingent of health care services, i.e. group of qualified family practitioners, surgical group, internists, nurses to an entire hospital which would otherwise close. I emphasize "FULL contingent" because (as my observations imply) smaller communities are unable to sustain their ability to provide a whole team of services and that is where the health care system falls apart as one or more segments are lost from the coordinated care. For example, if Obstetric services stop, Pediatric and Family care lose patients and skill sets for these patients are lost from the community.

I suggest to do this by requiring 5 years or more of commitment to a hospital in exchange for full education after high school. To coordinate this education with medical educational institutions that have a six year pathway to a medical degree, nursing degree or other health care degrees incorporating college and medical teaching. Some communities might be able to have local organizations or businesses sponsor local students. Bradford Hospital is a ready made opportunity for such an attempt to change the present paradigm. It had a full service hospital until recently. It had most of the ancillary staff. It has the physical plant. What it needs is an infusion of a full health care organization of providers. This cannot be done piecemeal. A full contingent of surgical specialities at once for example would have patients stay in the community rather than drive two hours in-state or drive out-of-state to find a full service: a few general surgeons, ENT surgeons, gynecological surgeons, urologic surgeons, gastrointestinal specialists. The phrase, " a center of excellence" has been overused but that is what is needed to maintain a full service health care system. In a rural community this might be able to be achieved if numerous providers start as a nucleus. To obtain that nucleus requires a coordinated effort from a larger source. The paradigm outlined above could do this. The hospital has a potential of drawing from 40,000 persons in the surrounding county.

Thank you,

Sincerely

Aris Gredzens, M.D.

Melinda Howard

My concern is the increase in the number of air and ambulance transports out of BRMC. How soon will it be before insurance companies refuse to pay for or pay part of this excessive expense? And why add to the treatment time of a patient by sending them out of area? And why add to a family's hardship by making them travel out of the area when they are concerned about an ill family member?

I know of two recent incidents in which children (one about a year old; the other two months old) were taken to the emergency room at BRMC. After a long day of testing the decision was made that BRMC couldn't determine the problem and so couldn't treat them. After waiting to find out if a hospital in Erie or Buffalo would take the child, they took a long, expensive ambulance ride to Buffalo. At 11pm, exhausted parents and sick child started the same process over in a different emergency room. And since only one parent can stay with the child the other must stay home or foot the bill for a hotel. That isn't health care.

Why not employ doctors to permanently staff BRMC, employ doctors that specialize in areas of medicine, have more than one doctor in the emergency room? Why not have doctors that can diagnose and treat? Not just start an IV and ship the patient out. Why not have surgeons available rather than patients having to travel to Pine Grove? You know, like the real hospital we used to have.

Thank you.

Pennsylvania Statewide Independent Living Council (PA SILC)

Website: www.pasilc.org

Hello. We are the Pennsylvania Statewide Independent Living Council (PA SILC). Each of the 50 states and 6 US Territories have a SILC under the Federal Rehabilitation Act of 1973 as amended and more recently under the Workforce Innovation & Opportunity Act (WIOA) of 2014. PA SILC's guidelines were further established in Pennsylvania under Act 139 of 1994 (Independent Living Services Act). Our mission is to use our collective power and legal mandate to develop and secure public policies that ensure civil rights and expand options for all people with disabilities in every aspect of life. We do this through execution of our State Plan for Independent Living (SPIL) which is based on comments from holding forums every 3 years or as needed across PA which guides our focus. PA SILC partners with the 17 Centers for Independent Living (CILs), other disability organizations and public entities to empower people with disabilities of all ages and backgrounds to live, work and play in our communities. While there have been improvements, access to rural healthcare for Pennsylvanians with disabilities, including Home & Community Based Services (HCBS) continues to have great barriers.

Thank you again for the opportunity to provide written testimony.

Areas under Rural Healthcare to address for Pennsylvanians with disabilities:

◦ **Lack of rural infrastructure- broadband (internet) and cell phone services:** While this may also be considered a general issue, it impacts the disability community's access regarding issues such as telehealth and meeting compliance standards for those with attendants regarding the Federal Electronic Visit Verification (EVV) of which some variation has to be implemented by state Medicaid programs specifically for certain in home services under PA Department of Human Services (DHS) for Office of Long Term Living (OLTL- physical disabilities, seniors) and some Office of Developmental Programs (ODP- Intellectual Disabilities, Autism). It is our hope that state and federal funds (including those in the Bipartisan Infrastructure Plan for PA) will help to bridge gaps there.

◦ **Limited Medicaid Network:** Many people with disabilities either rely solely on or at least have Medicaid as a primary or secondary health insurance. Many providers, particularly dentists, psychiatrists, and specialists, don't accept Medicaid in PA due to low reimbursement rates and paperwork requirements. Having healthcare coverage doesn't mean as much if you can't find local providers that accept your insurance which then requires travelling further from home.

◦ **Accessible facilities and equipment:** Many people with physical disabilities of all ages need to have accessible equipment to address their healthcare needs. Such equipment is not as available is rural communities. It often requires an entire day to travel from rural areas to other locations (Pittsburgh, Philadelphia, Hershey, State College, etc.) where these resources exist. Parents often have to take time off to accompany their children or adult children.

◦ **Transportation:** Many people with disabilities utilize public funded transportation options. Those include the Medical Assistance Transportation Program (MATP- under PA DHS), Shared Ride Programs (Persons With Disabilities -PWD under PennDOT and Senior Shared Ride under PA Dept. of Aging). While MATP is required to cross county lines, the other programs often don't. Many people with disabilities don't have vehicles and require the use of accessible vehicles which limits transportation options. If you can't get there, you can't get healthcare. This contributes to increased illness and lack of community as well as driving up costs when consumers end up going to hospitals for emergency care where the need for such trips is reduced through receiving more local healthcare (Primary Care Physician-PCP, Urgent Care, or home visits where applicable). Also see note on transportation for accessible facilities and equipment.

◦ **Covid-19:** Covid-19 has impacted people with disabilities more than other populations. Limits on transportation (number of trips, consumers per trip, masking, vaccination statuses of drivers and consumers, reduced drivers and trip options) have further restricted healthcare access since March 2020.

◦ **Medical System (Hospitals and other healthcare providers):** While Pennsylvania in general has a strong hospital and overall healthcare system in several aspects, there are a number of barriers for people with disabilities that exist, particularly even more in rural communities. Some examples include:

- **Lack of accessible communications:** People who are deaf require the use of a sign language interpreter and additional technology to communicate. Not all hospitals or medical providers are providing such access or at least on a consistent basis.

- **Consumer supports:** While ODP supports the use of direct support staff to accompany consumers into hospitals, OLTL has not done so at this time. The

policy for individuals with mental health requesting such assistance too under Office of Mental Health & Substance Abuse (OMHSAS) is unclear. Additionally, some hospitals have denied access to consumers, their families and other who are part of their support systems. While we understand the state concerns over safety (particularly during Covid-19), we believe that such restricts are wrong and in violation of the Americans with Disabilities Act (ADA). These restrictions also may not help the individual's health improve, which forces them to stay in the hospital longer which is unwise from both cost and access perspectives, as less restrictions may free up hospital beds, particularly at a time when hospitals are overbooked and understaffed.

- **Nursing Facility / Institutional Bias of medical staff and discharge planners:** Many people are discharged to a nursing facility or other institutional setting from hospitals without other options even meriting consideration. More education along with organizational policy, procedures and staff trainings need to be changed within our hospital and healthcare systems regarding available home and community-based services (HCBS) within rural areas for both hospital discharge planners and medical staff (physicians, nurses, and other hospital staff). The individual being discharged should be provided with sufficient resources to live in the community, including a list of all of the available local HCBS resources with referrals made prior to their discharge.

◦ **PA Long Term Care System: Continued shift away from nursing facilities / institutional care to HCBS- increased provider and wage rates:** We would be remiss in not reminding members of the PA General Assembly that there continues to be a need for increased funding for providers and the staff (attendants and others) that support those in the HCBS system. While this is not only more cost effective, Covid-19 has proven that in general that care at home or in other HCBS settings is usually safer for consumers, their families and those supporting them. While there has been some additional funding (including OLTL rate increases for HCBS programs), there is a still lack of equity and parity with nursing facilities and other institutional care. CILs and other OLTL HCBS providers have difficulty in competing for staff when other public and private sector employers are starting their employees out at higher wage rates with benefits (healthcare, education, other incentives) due to limited public funding. Without an ability to meet staffing needs, more people (people with disabilities and seniors needing long term care) with will forced into more expensive and less safe options which also offer less consumer control or individual freedoms.

Thank you for the opportunity to offer written testimony. Please feel free to contact us on rural healthcare and other issues as the PA House Republican Policy Committee seeks input regarding various future budget and policy matters.

Recent years our area has seen the closure of two inpatient geriatric facilities. One in Saint Marys at Penn Highlands Elk and the other at neighboring Potter County which many of the McKean County residents utilized. Our older population must now travel to Dubois, Brookville or Clearfield and that is only IF there is an open bed at those facilities. In reality; they could be placed further out of the area if there are needs for inpatient geriatric psyche.

Our older folks have great difficulty accessing transportation and in turn often do not see a doctor as often as they should. A suggestion would be to revisit the idea of in home visits for health care. Home Health is a great tool; however, with recent restriction on home health a doctor visit has to be done within 30 days prior to home health being ordered. If you cannot get to the doctor; you cannot even get Home Health nurses into the home.

Many years ago there was a great deal of effort put in to reducing hospitalizations and there were many groups formed to help with transitions of care. Unfortunately, our elderly are struggling at home after hospital stays with lack of a smooth transition with medications being a huge problem. Older adults often times need someone to assist with medications and those resources have dried up.

Another general statement: In the last 10 years multiple smaller personal care homes have closed, Dom Cares have closed and all of these closures due to lack of any increase in funding for individuals that may need SSI to pay for the stays in these facilities. These facilities were no longer able to financially survive.

I am sure you are aware of the most recent downsizing of the Bradford Regional Medical Center. This occurred with no local access to an urgent care center for the local residents. More urgent care centers are needed.

It is unfortunate that our elders wish to remain at home as long as possible and now we lack workers to even care for our elderly and disabled in the community. I am not sure how to tackle this problem but it is a great concern that our elderly and disabled are sometimes forced into facilities due to lack of direct care workers. We know they have better outcomes and better quality of life if able to age in place, in their home.

I also understand that much of the staffing shortage is due to the current pandemic, however, we are heading towards a time in coming years when the sheer numbers of our elderly will increase dramatically. I believe we are unprepared for the amount of individuals with cognitive impairments that we will see. I believe we need to increase the amount of adult day facilities and encourage insurance to pay for these services; they are underutilized due to cost and they are in reality one of the most cost effective services available.

I think we need to look at more shared housing and ways to connect seniors living alone with others that may be able to share housing, bills, and support each other.

I thank you for taking my concerns.

Barbara Paul, RN
Director Long Term Care
Protective Services, Caregiver Support Program, OPTIONs and Dom Care

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Congress of the United States
House of Representatives

January 19, 2022

The Honorable Martin Causer
House Majority Policy Committee Chairman
67th District, Pennsylvania House of Representatives
147 Main Capitol
PO Box 202067
Harrisburg, PA 17120-2067

Dear Chairman Causer:

I write to submit my public comments for the January 19, 2021, Pennsylvania House Majority Policy Committee public hearing on rural health care issues. As the member who represents nearly 25 percent of the landmass of Pennsylvania, which is vastly rural, I am keenly aware of the problems constituents face when accessing medical services.

Prior to being elected to Congress, I spent nearly three decades as a therapist, rehabilitation services manager and a licensed nursing home administrator. As a result, I have learned firsthand the importance of access to quality health care in rural communities and have become a strong advocate for increased access, affordability, quality of care, and patient choice. I came to Washington to help address the many challenges we face in health care and advance these same principles.

On March 25, 2010, Congress passed sweeping legislation, which fundamentally realigned our nation's health care system. Since passage of this bill, my worst nightmares have become a reality as the law's implementation continues to drive up costs, saddle small businesses with burdensome regulations, and impose unfunded mandates on the Commonwealth, by shifting costs from the federal government to the states.

Luckily, Congress has been able to repeal key components of the bill since it was first enacted, including the individual mandate. As we move forward, we must provide commonsense reforms that improve our nation's health care system and access across the country, including those in rural America.

During my tenure in Congress, and especially through the COVID-19 pandemic, we have seen the use of telehealth increase dramatically. Health care providers, including federal qualified health centers (FQHC) and rural health clinics (RHC), have adopted telehealth to safely provide care to individuals throughout the Nation. These services include routine health care, such as wellness visits; medication consultation; dermatology; eye exams; nutrition counseling; and mental health counseling. The ability to use telehealth services during this crisis has demonstrated how this technology can play a pivotal role in improving health equity by increasing access to care for the vulnerable populations, particularly in rural America.

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For these reasons, I have introduced several pieces of legislation related to improving health care delivery. Most recently, I introduced H.R. 4437, the Helping Ensure Access to Local TeleHealth (HEALTH) Act, which codifies Medicare reimbursement for telehealth services rendered by FQHCs and RHCs. The bill also allows these health facilities to continue to utilize audio-only telehealth visits for patients who do not have access to quality broadband.

The spread of COVID-19 has caused significant disruptions to all Americans, businesses, and hospitals. This includes physical lockdowns, quarantines, loss of revenues, staffing and equipment shortages, supply chain issues, among other items. There has also been a great deal of misinformation circulating about action in the House of Representatives to create a so-called "vaccine database." These claims are simply untrue.

The House passed H.R. 550, the Immunization Infrastructure Modernization Act of 2021 on November 30, 2021 to improve Immunization Information Systems (IIS). These systems have been in place for more than 20 years and already exist in all 50 states and territories. Let me be clear: IIS is not a vaccine database used to track individuals. Nor does the legislation include any type of punitive measures for those individuals who have chosen not to receive a vaccine. The bill simply modernizes IIS while adding further protections to guarantee these systems remain safe and private.

As a staunch opponent of the Biden Administration's unconstitutional vaccine mandates, vaccine passports and other un-American proposals, please be assured I will never support legislation that puts individuals' private medical information at risk. While I highly encourage all eligible Americans to carefully weigh the benefits of receiving a COVID-19 vaccine, I support each individual's decision to be vaccinated and will continue to pursue and support policies that allow our country to function safely and effectively.

I thank Chairman Causer for the opportunity to share my comments on health care challenges in rural communities. It is imperative that rural Americans can conveniently and confidently access health care services. As elected officials, we must always strive to eliminate the barriers that rural residents have encountered when seeking to obtain the care they need and deserve.

Sincerely,

Glenn "GT" Thompson
MEMBER OF CONGRESS