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HB 2366 – Allowing apparatus operators to provide ground ambulance transportation for certain patients in rural areas.

Joseph House, Paramedic
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Opponent Testimony

Chairman Hineman and members of the committee, thank you for the opportunity to appear before you today and although we are providing testimony in opposition of this bill as currently drafted, please understand that the Emergency Medical Services Board sees this bill as a means to continue a conversation. We believe we have a shared desire with the committee and the group that requested this bill's introduction to understand the root cause of the underlying issue and to implement a safe, appropriate, and effective solution to address that underlying issue. We continue to be more than happy to work with all interested parties to form a workable solution.

Minimum Staffing Requirement History

Minimum staffing requirements for an ambulance transporting a patient has been at least 2 EMS certified persons since September 1, 1992. This was around the same time that the First Responder level of certification was created. This change was published in regulation on August 27, 1990 when it was further detailed what constituted an appropriate certification for CPR and First Aid before 1/1/1992 and required the person to be at least certified as a First Responder on and after 1/1/1992. May of 1987 was the most recent date where the minimum staffing allowed a single EMS provider to transport a patient and it was specific to only a Type 4 ambulance service which was not allowed to be used on any patient considered to be experiencing an emergency. The Emergency Medical Services Board began its existence in April of 1988.

In 1997, the Emergency Medical Services Board allowed the 2nd person on an ambulance to be a physician, physician assistant, or registered nurse. In 2014, the Emergency Medical Services Board added an advanced practice registered nurse to that list.

Concerns/Issues with HB 2366

HB 2366 appears to make an attempt to address a symptom present within a significantly more complex and larger problem. A larger problem that is not unique to ambulance services and one that is not unique to only those services in rural areas of our state. This problem is limited availability of resources. For ambulance services, those limiting resources are predominantly available personnel and ambulances. HB 2366 attempts to provide a scenario and situation where availability of personnel could be stretched in order to maintain the number of available ambulances for 911 coverage.

There are significant issues present within the currently drafted version of HB 2366, but we believe the intent was to allow the transport of a patient that simply needs to get from Hospital A to Hospital B to be transported by an ambulance service with a healthcare provider (EMS or other) taking care of the patient and no requirement for the 2nd person on that ambulance to hold, at a minimum, EMS certification. This seems similar to the pre-Board Type 4 ambulance service minimum staffing.

The concerns/issues we have identified in HB 2366 are:

- Definition of "Stabilized transfer" – trying to define "stable" in words is difficult, this definition came close, but missed the mark. As an example, a patient diagnosed as having status seizures, seizures that will not stop, and is expected to continue that seizure activity throughout

transport could qualify to have a single provider on the ambulance. This is one scenario where there is a high likelihood of needing two medically trained persons on the ambulance and is absolutely necessary for the safety and well-being of the patient.

- Reimbursement – another issue with defining "stable" is that 2 conditions must be met to be eligible for reimbursement from Medicare/Medicaid. 1) Patient was transported by an approved supplier of ambulance service, and 2) The patient was suffering from an illness or injury which contradicts transportation by other means. That 2nd condition is the more difficult portion to meet especially with a "stable" patient.
- Limiting this to a rural area – where we appreciate the law being drafted in a manner to limit this practice to only rural areas, our statutes and regulations are typically developed and implemented in an effort to protect the safety and welfare of the public. This solution is either safe for use or not safe for use – there should not be a difference in safety between rural and urban.
- Apparatus operator training – we have concern over the potential burden of requiring completion of an emergency vehicle operator course and the completion of a refresher course every two years. Some ambulance services do this for current personnel in order to keep insurance premiums lower, but many do not perform this type of continual training. Without requiring emergency vehicle operator courses or refreshers in current regulation, we have not seen a high incident rate of ambulance related accidents.

Every day, many ambulance services across our state are making a very difficult decision: perform a hospital to hospital transfer or maintain adequate 911 coverage. For county commissioners and the other ambulance service operators, this becomes increasingly more difficult. A business model decision says to do what generates more revenue than expense in order to keep other subsidies lower. A human nature decision says to maintain 911 because maybe my loved one, or my neighbor, will need that ambulance. Healthcare consistently tries to maintain that balance. In a utopic environment, that decision never needs to be made because resources are available to appropriately do both when the need occurs.

This bill exists because resources statewide are inadequate to cover that need and that inadequacy is more marked in rural areas of our state. We need to find a way to minimize the number of times that difficult decision must be made, however the Emergency Medical Services Board does not believe that HB 2366, as currently drafted, achieves that goal without causing the listed concerns/issues.

We appreciate the Kansas Legislative Policy Group, specifically the Hamilton County Commission, as well as Edwards County Hospital for identifying this issue and providing a starting point.

We believe we could provide an alternative solution that could be considered to achieve the same intent of this bill of hospital to hospital transfers of medically necessary, stable, and non-critical patients with a minimum of 1 EMT or higher on the ambulance and within the Board's current statutory authority. We believe that a 6-9 month study period could be attained through the current temporary variance process afforded to the Emergency Medical Services Board in K.S.A. 65-6111 subsection (b) through K.A.R. 109-2-9. The variance process allows the board to impose conditions upon any granted variance. These conditions could be used to better define "stable" and to gather the information necessary to formulate a better, and more permanent, policy decision.

They say that if you do not learn from history, you are bound to repeat it. Our preference is to have a path that provides the Board an evidence base supporting change in statute or regulation.

The Emergency Medical Services Board opposes HB 2366 in its current form and would be open to consider alternative solutions, especially those that do not require an immediate statutory enactment.

We appreciate your time in hearing our concerns and your consideration of our provision of an alternative solution. I am happy to stand for questions at the appropriate time.