PENNSYLVANIA RURAL HEALTH TRANSFORMATION PLAN
ACCESS AND CARE DELIVERY

CENTER FOR RURAL PENNSYLVANIA PUBLIC HEARING
MAY 6, 2026

PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL
Your Voice In EMS.

Prepared Testimony of:
Dr. Alvin Wang, DO FAAEM FAEMS NRP
President, Pennsylvania Emergency Health Services Council
awang@pehsc.org

Pennsylvania' Rural Health Transformation Plan: Access and Care Delivery

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Mr. Chairman, members of the committee, thank you for the opportunity to testify today.

My name is Dr. Alvin Wang. I serve as the President of the Pennsylvania Emergency Health Services Council and as the Regional EMS Medical Director for Montgomery County. I am also dual board-certified in Emergency Medicine and Emergency Medical Services, and I maintain my national and Pennsylvania paramedic certifications independent of my physician licensure, which allows me to remain closely connected to frontline EMS practice.

I have been continuously involved in EMS in Pennsylvania since 1995, starting as an EMT and advancing through roles as a paramedic, EMS educator, and flight paramedic, and now as an EMS physician. My work has spanned rural, suburban, and urban systems, including volunteer-based agencies, high-volume municipal services, and academic healthcare environments.

This breadth of experience has given me a longitudinal perspective on how EMS functions across the Commonwealth, not just at the bedside, but as a system. I have seen firsthand how differences in funding, workforce structure, and access to resources translate into measurable differences in patient outcomes, health equity, and system reliability.

It is from that perspective that I offer my comments today in support of the Commonwealth's Rural Health Transformation Plan, and more specifically, to highlight both its strengths and the critical elements required to ensure its success.

Rural communities across Pennsylvania face persistent and compounding challenges, including hospital closures, workforce shortages, longer transport times, and an aging population with increasingly complex medical needs. In this environment, access to care can no longer be defined solely by traditional brick-and-mortar facilities. Instead, access must be reimagined as a coordinated system that meets patients where they are, including in their homes and communities.

EMS is uniquely positioned to serve as a primary access point to the healthcare system in these settings. In many areas of the Commonwealth, EMS clinicians are often the only

healthcare professionals available 24 hours a day, seven days a week. They are often the first, and at times the only, point of contact for patients experiencing both emergent and non-emergent conditions.

The plan correctly identifies EMS as the frontline of care in rural communities. It recognizes the challenges of workforce instability, infrastructure gaps, and limited access to care. These are accurate assessments. However, EMS is not simply the frontline of care. It is the entry point into the healthcare system itself. How we design policy around EMS will determine not just access, but outcomes, cost, and system stability.

The plan makes meaningful progress in several important areas. It invests in modernization of EMS infrastructure, including equipment and operational capability. It acknowledges EMS as a professional workforce, which is essential for recruitment and retention. And it begins to expand innovative models such as community paramedicine and mobile health, which have already demonstrated success in improving access and reducing hospital utilization.

Community-based models, particularly Mobile Integrated Health and community paramedicine, offer a practical and evidence-informed pathway to expand access and improve outcomes. These programs allow EMS clinicians to conduct in-home assessments and follow-up visits, support chronic disease management, and provide post-discharge care aimed at reducing hospital readmissions. In rural settings, where clinician shortages are most acute, these models can fill critical gaps in care delivery.

However, while these models hold significant promise, they cannot be successfully implemented or sustained without a sufficient EMS workforce. Across rural Pennsylvania, EMS agencies are facing significant staffing shortages. Many rely on a shrinking pool of volunteers, while career services struggle to recruit and retain qualified clinicians due to low reimbursement, wage disparities compared to other health professions, and increasing job demands. EMS is a highly specialized discipline that lives within the domain of both public safety and healthcare. EMS clinicians do not merely provide emergency transportation. They are the backbone of a readiness-based system that responds to acute illness, injury, disaster, and public safety and health needs within their community.

This workforce reality creates a fundamental operational constraint. EMS agencies do not have excess capacity to layer community-based programs on top of already strained emergency response obligations.

There is a structural issue that must be addressed for these investments to succeed.

Today, EMS is funded primarily through a fee-for-transport model. That means we are reimbursed when we move a patient, not when we care for a patient. This creates a

fundamental misalignment. We are being asked to provide advanced clinical care in the field, expand community-based services, and improve system efficiency, while still being financed as a transportation service.

This funding gap has direct and significant implications for workforce stability. Paramedics invest approximately 1,200 to 1,500 hours in training to develop a highly specialized clinical skillset. Yet with only a modest amount of additional education, many are able to transition into other healthcare roles with substantially higher compensation. As a result, EMS systems often function as a training ground rather than a sustainable career destination.

We need skilled prehospital clinicians at all levels to care for patients in our Commonwealth. These are distinct and complementary roles within the healthcare system. However, without a funding model that supports competitive compensation and career sustainability within EMS, we will continue to struggle with retention and workforce stability.

Funding for EMS should not be tied strictly to call volume or transport. EMS agencies must be supported and reimbursed for their readiness to respond at a moment's notice to an emergency, regardless of where it occurs in the Commonwealth. Although not every 9-1-1 call represents a time-sensitive condition, many do, including stroke, cardiac arrest, and other life-threatening emergencies.

We recognize that outcomes of these conditions can vary based on geography. However, we should strive for a system in which the likelihood of neurologically intact survival from an out-of-hospital cardiac arrest is not determined by whether a patient happens to be in a densely populated urban area or a rural community. Achieving that goal requires a funding model that supports readiness and equity in coverage, not just utilization.

Without addressing this mismatch, we risk building programs that cannot be sustained once grant funding ends.

There is also an important role for insurers in ensuring alignment with the goals of this plan.

Health plans benefit from reduced emergency department utilization and avoidable hospital admissions, yet current reimbursement policies often do not support EMS-based interventions that achieve those outcomes. Mobile Integrated Health and community paramedicine programs, which can deliver care in lower-cost settings and improve care coordination, are frequently unreimbursed or inconsistently covered. Insurers that reimburse only for transport are covering only a small fraction of the true cost of maintaining readiness.

To fully realize the goals of the Rural Health Transformation Plan, payer policies must evolve to support clinically appropriate care delivered in the field, rather than incentivizing care only after patients enter higher-cost settings.

In addition, many rural EMS agencies continue to operate with aging ambulances, outdated medical equipment, and limited access to enabling technologies. Strategic investment is needed not only in vehicles and equipment, but also in robust telemedicine capabilities that allow EMS clinicians to connect with EMS-trained physicians in real time. It is important to recognize that broadband limitations, particularly in the northern tier of Pennsylvania, present a real barrier to implementing these solutions. Bidirectional EMS data integration within patient care data systems such as Health Information Exchange (HIE) are essential for EMS to function effectively as part of an integrated care delivery system. Pennsylvania already has statewide HIE architecture through the Pennsylvania eHealth partnership and the Public Health gateway which means a foundation exists for HIE sharing, but EMS agencies lack the staffing, funding, and vendor integration to make those systems operationally useful in the field. The policy implication here is clear – we don't necessarily need to invent new architecture – we must fund EMS on-ramps into the infrastructure that the Commonwealth already maintains.

EMS is already filling critical gaps in care delivery, often quietly and without adequate support. With the right policy framework, investment, and recognition, EMS can play a central role in improving access, enhancing care coordination, and sustaining rural health systems across the Commonwealth. My caution here is operational: rural EMS agencies cannot build MIH on top of hollowed out emergency response systems. For MIH to succeed, workforce stabilization and readiness-based reimbursements are prerequisites. Otherwise, MIH becomes an unfunded add-on mandate to crews which are already stressed to provide basic coverage. The sequence of reform matters greatly here.

The Pennsylvania Emergency Health Services Council plays a central role in this process. PEHSC is a multidisciplinary body that brings together EMS clinicians, physicians, educators, regulators, and system leaders from across the Commonwealth. It serves as a critical forum for gathering stakeholder input, building consensus across diverse perspectives, and translating that input into practical, evidence-informed policy recommendations.

In many ways, PEHSC functions as an early signal detection system for emerging challenges within EMS, while also providing a structured pathway to align stakeholders around solutions. As this plan moves forward, continued engagement with PEHSC will be essential to ensure that implementation reflects operational realities across rural, suburban, and urban systems.

In closing, the Rural Health Transformation Plan represents a significant and important investment in EMS. To fully realize its potential, we must ensure that funding models align with care delivery, that EMS is recognized as a clinical partner within the healthcare system, and that workforce and infrastructure challenges are addressed at a structural level.

If we do that, EMS will not only support rural healthcare. It will help transform it.

Thank you for your time, and I look forward to your questions.

Respectfully submitted,

Alvin Wang