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Ambulance Association of Pennsylvania

720 Montour Road
Loysville, PA 17047
Toll Free: 1-888-AMB-9121
Phone: 717-789-9090
Fax: 717-789-9091
www.aa-pa.org

November 16, 2006

Mr. Gerald Radke, Director
Bureau of Facility Licensure and Certification
Department of Health
Room 932, Health and Welfare Building
7th and Forster Streets
Harrisburg, PA 17120

Dear Mr. Radke:

The Ambulance Association of Pennsylvania (AAP) submits the following comments on the proposed regulations to 28 Pa. Code Chapter 101 (relating to general information regarding general and special hospitals). The AAP clearly understands the noble intent of the Department of Health in proposing minimum requirements for the physical and psychological treatment of sexual assault victims; however the direct effect of these proposed regulations on the ambulance provider community may be more substantial than just a simple transport component.

There are five major questions that the Department must clarify in regard to intent for these proposed regulations regarding the transportation of sexual assault victims to hospitals that provide sexual assault emergency services and between hospitals that do not.

1. Is it the intent of the Department in these proposed regulations to have hospitals utilize the ambulance provider community regarding the arrangement for the immediate "non-medically necessary" transfer of a sexual assault victim between a hospital that does not provide sexual assault emergency services and one that does?

2. If the intent of the Department is to mandate transportation by ambulance, what statutory authority does the Department cite to mandate an ambulance service to provide the immediate non-medically necessary transfer of a sexual assault victim at no cost between a facility that does not provide sexual assault emergency services and one that does?

3. Does the transportation of a sexual assault victim, as defined in the proposed regulations, invoke the transfer requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA), or US Code Title 42, 1395dd, if that sexual assault victim is transported by any other means than an ambulance or "qualified personnel and transportation equipment" between a hospital that does not provide sexual assault emergency services and one that does? Does the "stabilization" of a sexual assault victim at a facility that does not provide sexual assault emergency services include the psychological component or treatment of the sexual assault victim?

4. When a sexual assault victim is also a physical assault victim, what takes precedence in the treatment of the sexual assault victim? When does the traumatic and medical aspect of patient care outweigh the Department's need to have this individual transferred to hospital that provides sexual assault emergency services and what role does medical command play in this decision?

5. Does the bypass of the closest appropriate acute care facility to treat the sexual assault victim medically, or the right of patient choice, contradict the Department's own existing guidelines and approved protocols in regards to emergency medical service treatment and transportation guidelines? Again, when does the collection of evidence and supportive services outweigh an existing medical or traumatic issue?

Additionally, AAP is concerned that the potential unintended consequence of this proposed regulation, should it be passed, would be a decrease in the number of hospitals providing such services. Rural and some urban hospitals already burdened with staff and cost issues will probably opt-out of providing emergency sexual assault services. The increase of hospitals that choose not to provide emergency sexual assault services will directly impact the EMS System from a delivery standpoint through an availability and time aspect.

For instance, should a small rural ambulance service in a county with limited access to an acute care facility either have to treat and transport or transfer a sexual assault victim to a far distant hospital, this transport may remove the only available service in a specific geographic area for a lengthy amount of time. Increased transport times and mileage translate into decreased availability, increased response times and increased personnel and vehicle maintenance costs.

The Department includes the transportation at no cost to the victim of sexual assault in the proposed regulation. No consideration appears to be given to cost burden by ambulances that have already transported the sexual assault victim from a scene. We again would question the Department's intent to whether the "no cost" mandate would

carry over to the emergency transportation and treatment aspect of the sexual assault victim.

It is understandable that a victim of sexual assault should not have to worry about the cost incurred from their exam, evidence collection and transportation, however, the ambulance provider community already loses millions of dollars annually from uncompensated care and payments well below the cost of providing such services by Medicare, Medicaid and other third party insurers. The Commonwealth itself has stipulated through statute, rate-controlled fees with Worker's Compensation, Auto Insurance and Medicaid. This proposed regulation would be another unfunded mandate of government on an already fragile ambulance provider community

In conclusion, the Department needs to clarify intent with reference to the five above comments in regards to, who or what entity will provide transportation between hospitals, what statutory authority exists to mandate that transportation, does the use of other means of transportation other than an ambulance between hospitals violate EMTALA and when does medical control in regard to the health of the sexual assault victim outweigh the transfer of this victim to a possibly further, medically inappropriate hospital?

Thank you for the opportunity to comment on these proposed regulations.

Sincerely,

Barry Albertson, Jr.
President

Cc: Alvin C. Bush, Chairman, IRRC
Senate Public Health & Welfare Committee
House of Representatives Health & Human Services Committee
Joseph Schmider, Director, Bureau of EMS