Indiana EMS in Crisis: Pathways to Recovery

Introduction

Indiana's Emergency Medical Services (EMS) system is under mounting pressure, particularly in rural areas where Critical Access Hospitals (CAHs) rely on timely interfacility transfers (IFTs) to deliver lifesaving care. The state has experienced a dramatic increase in EMS demand—rising from approximately 750,000 runs in 2018 to over 1.25 million in recent years—while the number of certified EMS personnel and ambulances has declined.[1] This imbalance has led to delayed transfers, coverage gaps, and increased burnout among EMS and hospital staff. Addressing these challenges requires a coordinated, statewide strategy that blends immediate stabilization with long-term structural reform.

Workforce and Systemic Challenges

Indiana's EMS system is facing compounding workforce and structural pressures that threaten its ability to meet both emergency response and interfacility transfer demands—particularly in rural areas. The reasons can be:

1. Shrinking Workforce and Burnout
   Indiana's EMS workforce has declined significantly. The number of certified Emergency Medical Technicians (EMTs) dropped from 14,700 in 2017 to about 13,200 in 2022[2]. Simultaneously, the state lost over 300 paramedics, even as EMS call volume surged by 66% between 2018 and 2021. Burnout and mental health concerns are major contributors to attrition. A 2023 workforce assessment found that 23–24% of former EMS workers cited burnout as a key reason for leaving the field.[1] Long shifts, trauma exposure, and modest pay drive high turnover, with many EMTs opting for more stable and better-paying jobs in manufacturing or hospital settings.

2. Career Limitations and Internal Competition
   EMS professionals face limited career advancement opportunities. Beyond becoming a paramedic or administrator, few roles exist for growth within the field. This lack of upward mobility pushes skilled individuals toward other healthcare sectors. Hospitals and clinics often recruit EMS-certified personnel for roles with better hours and pay, further draining the field. These individuals may retain certification but no longer serve in active EMS roles, skewing workforce statistics and masking the true shortage.[3]

3. Volunteer Fragility and Rural Gaps
   Rural EMS systems rely heavily on volunteers—34% of EMS providers are volunteer fire departments (IDHS EMS, 2024). However, aging volunteers and economic pressures are eroding this model. In Knightstown (Henry County, Indiana), the closure of a long-standing

volunteer ambulance service in 2022 left residents with response times exceeding 45 minutes.[4] Some counties lack advanced life support (ALS) coverage entirely, operating with basic EMTs or relying on neighboring counties for ALS intercepts. These fragile systems can collapse when just one or two volunteers step away.

4. Financial Instability and Reimbursement Gaps
   EMS agencies operate under chronic financial strain. Reimbursement rates often fail to cover the true cost of service. One provider reported expenses of $633 per run, with insurers reimbursing as little as $200.[5] Although Indiana passed House Bill 1385 in 2024 to mandate higher private insurance payments, most EMS agencies still rely on government subsidies, grants, and community fundraising. Without sustainable revenue, agencies struggle to recruit, retain, and equip staff—perpetuating the cycle of shortages and service cutbacks.[6]

5. Transfer Delays and Systemic Bottlenecks
   IFTs are frequently delayed due to EMS shortages. Emergency 911 calls take precedence, leaving hospitals waiting hours for transfers. Long-distance transports remove ambulances from their communities for extended periods, creating coverage gaps and operational bottlenecks. Small hospitals face overcrowded emergency departments and staff burnout when transfers are delayed. These delays not only compromise patient care but also strain hospital workflows and morale.[7]

Lessons from Other States

Maine's Blue-Ribbon Commission on EMS declared the system "at the edge of a cliff" and recommended permanent oversight, essential service designation, and regional coordination. Legislative reforms followed, including the introduction of stipends and retirement benefits for volunteers.[8] Indiana could emulate this holistic approach with a dedicated EMS task force. Kansas passed HB2280, allowing single-EMT ambulances in counties under 30,000 residents. While this measure is controversial, it helps maintain service in areas where staffing two EMTs is impossible.[9] Indiana may consider similar flexibility for its most rural regions as a temporary solution.

Strategic Recommendations for EMS Sustainability

Indiana must adopt a unified strategy that addresses both immediate needs and long-term sustainability. The following recommendations integrate short- and long-term solutions into a cohesive framework:

1. Establish Regional Transfer Coordination Hubs
   Indiana's creation of Regional Transfer Coordination Hubs will assist Indiana with developing its emerging Regional Medical Operations Coordination Centers. These hubs would facilitate real-time communication and resource sharing across counties, improving IFT efficiency and reducing idle vehicle time.

2. Expand EMS Education and Training Access
   Only 61 of Indiana's 92 counties currently offer local EMT or paramedic training.[2] The state should invest in regional EMS education hubs and subsidize instructor salaries to expand capacity. "Grow-your-own" scholarships for rural high school graduates who commit to

serve locally can reinforce community retention and build a sustainable pipeline of EMS professionals.

3. Deploy Targeted Workforce Incentives
   To address immediate staffing shortages, Indiana should use the newly allocated $4.1 million EMS Fund to offer short-term bonuses (e.g., $200 per transfer shift) and tuition reimbursement for new EMTs. These incentives can attract personnel to high-need rural areas and support retention during critical staffing gaps.[10]

4. Formalize Mutual-Aid and "No-Border" Agreements
   Many EMS agencies already rely on informal mutual-aid arrangements, but these lack standardized funding and activation protocols. Indiana should formalize mutual-aid and "No-Border" agreements across counties and state lines. Standby contracts with neighboring or private providers can ensure continuous coverage when a local service goes offline.[6]

5. Designate EMS as an Essential Public Service
   Indiana should statutorily define EMS as an essential service, enabling dedicated county taxing districts and state appropriations. Creating an Indiana EMS Trust Fund—modeled after Pennsylvania and Utah—could pool insurance surcharge revenue to provide annual grants for rural operations.[11]

6. Scale Community Paramedicine and Mobile Integrated Health
   Embedding EMS within the broader healthcare system ensures both sustainability and value. Scaling Mobile Integrated Health (MIH) and Community Paramedicine programs statewide would expand EMS roles into preventive and post-acute care. These programs diversify funding through Medicaid waivers and hospital partnerships while offering EMS professionals career variety and stability (Centers for Medicare & Medicaid Services.[12]

7. Collaborating with Local/Regional/Statewide EMS Programs.
   The Indiana Transfer of Care (InTOC) Network is well-positioned to lead pilot efforts in collaboration with hospitals and Emergency Medical Services (EMS) agencies across Indiana. Building on its established partnerships and statewide footprint, InTOC can serve as a convener and implementation hub to test innovative, data-driven approaches to improving interfacility transfers and patient flow. At the statewide level, InTOC's pilots can generate actionable insights and best practices that inform policy, workforce planning, and sustainable models for EMS-hospital collaboration, particularly in rural and underserved communities.[7]

Conclusion

Indiana's EMS system is at a critical juncture. Persistent workforce shortages, financial instability, and rural fragility threaten the state's ability to deliver timely emergency and transfer care. However, with coordinated leadership and sustained investment, Indiana can build a resilient, equitable EMS infrastructure. By integrating short-term incentives with long-term reforms—such as education expansion, essential service designation, and community paramedicine—Indiana can ensure that every Hoosier, regardless of geography, receives dependable emergency care.

References

1. Bowen Center. (2023). *Indiana EMS Workforce*. https://www.in.gov/dhs/files/indiana-ems-workforce-assessment-2023.pdf.
2. IDHS. (2025). *INDIANA EMS 2025 REPORT*. https://www.in.gov/dhs/files/indiana-ems-2025-report.pdf
3. Kinney, K. (2022). INDIANA EMS WORKFORCE SHORTAGE - 2022. *2022*. https://www.in.gov/dhs/files/Indiana-EMS-Workforce-Shortage-2022.pdf
4. WRTV. (2022). *Local Knightstown ambulance service struggles to stay afloat.* https://www.wrtv.com/news/local-news/henry-county/local-knightstown-ambulance-service-struggles-to-stay-afloat
5. ICC. (2024). Ambulance insurance payment bill advances over business objections. *2024*. https://indianacapitalchronicle.com/2024/02/15/ambulance-insurance-payout-bill-advances-over-business-objections/
6. Indiana Public Law. (2024). *INDIANA PUBLIC LAW 67- 2024 DATA REPORT*. https://www.in.gov/dhs/files/public-law-67-2024-survey-results-report.pdf
7. IRHA. (2024). *Indiana Transfer of Care Network*. https://www.indianaruralhealth.org/services/indiana-transfer-of-care-network
8. wgme. (2025). *Maine bill aims to reform EMS system, addressing workforce shortages and rising costs*. https://wgme.com/news/local/maine-bill-aims-to-reform-ems-system-addressing-workforce-shortages-and-rising-costs
9. ksn. (2025). *House Bill on EMS heads to governor's desk; could change response in rural Kansas*. https://www.ksn.com/news/state-regional/house-bill-on-ems-heads-to-governors-desk-could-change-response-in-rural-kansas/
10. EMS Commission. (2025). *EMERGENCY MEDICAL SERVICES COMMISSION MEETING MINUTES*. https://www.in.gov/dhs/files/EMS-Commission-05.09.25-Minutes-DRAFT.pdf
11. National Conference of State Legislatures. (2023). *State Policies Defining EMS as Essential*. https://www.ncsl.org/health/state-policies-defining-ems-as-essential
12. *Critical Access Hospitals | CMS*. (n.d.). Retrieved July 28, 2025, from https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals