Agenda: Battle Creek City Commission

Meeting Type: Workshop

Meeting Date: March 4, 2025

Location: City Commission Chambers - City Hall - 3rd Floor

Chair: Mayor Mark A. Behnke - Topic: Ambulance Contract Work Session

City Commission

WELCOME AND INTRODUCTION

PUBLIC COMMENT-LIMITED TO 3 MINUTES PER INDIVIDUAL

PRESENTATION BY RON SLAGELL, PRESIDENT AND CEO OF EMERGENT HEALTH PARTNERS

COMMISSION DISCUSSION

ADJOURNMENT

Citizens who wish to address a specific issue on the floor may do so at any time after being recognized by the Mayor or presiding Commission. At the time for public comments, after being properly recognized, citizens may address the commission on any subject. Citizens will be subject to the following limitations:
1. Citizen comments on any Resolution before the Commission may be made either before or after the Commissioners have had an opportunity to discuss the Resolution, at the discretion of the Chair;

2 .Citizens wishing to speak to a particular Resolution should raise their hands and wait to be recognized before speaking;

3. Citizens will confine their remarks to matters currently pending on the floor, and be brief and concise in making their remarks;

4. If a citizen becomes repetitive or, in the opinion of the Chair, takes an inordinate amount of time in making comments, that citizen will be ruled out of order and the Commission will continue with its business;

5. Citizens should address all remarks to the Commission as a whole, and not to individual Commissioners.

These Rules will apply to comments by citizens during the Public Comment section of the Agenda.

The City of Battle Creek will provide necessary, reasonable, auxiliary aids and services, such as signers for the hearing impaired, and audiotapes of printed materials being considered in the meeting, upon seven days' notice to the City of Battle Creek. Individuals with disabilities requiring auxiliary aids or services, should contact the City of Battle Creek by writing or calling the following:

Victoria Houser
Office of the City Clerk
Post Office Box 1717
Battle Creek, Michigan 49016
269/966-3348 (Voice)
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Item Title: PRESENTATION BY RON SLAGELL, PRESIDENT AND CEO OF EMERGENT HEALTH PARTNERS

ATTACHMENTS:

Description	File Name	Type	Upload Date
2022.02.14-Joint-Statement-on-Red-Light-and-Siren-Operations-with-Logos-FINAL	2022.02.14-Joint-Statement-on-Red-Light-and-Siren-Operations-with-Logos-FINAL.pdf	Backup Material	2/26/2025
Joint Statement on EMS Performance Measures Beyond Response Times - FINAL Approved by Named Associations 4-30-24	Joint_Statement_on_EMS_Performance_Measures__Beyond_Response_Times_-_FINAL_Approved_by_Named_Associations__4-30-24.pdf	Backup Material	2/26/2025
EMS System Overview, City of Battle Creek Commissioner workshop, 3.4.25	EMS_System_Overview__City_of_Battle_Creek_Commissioner_workshop__3.4.25.pdf	Backup Material	2/26/2025
EMS on Life Support, EMS1 Article 2.20.25	EMS_on_Life_Support__EMS1_Article_2.20.25.pdf	Backup Material	2/26/2025

Joint Statement on Lights & Siren Vehicle Operations on Emergency Medical Services (EMS) Responses

February 14, 2022

Douglas F. Kupas, Matt Zavadsky, Brooke Burton, Shawn Baird, Jeff J. Clawson, Chip Decker, Peter Dworsky, Bruce Evans, Dave Finger, Jeffrey M. Goodloe, Brian LaCroix, Gary G. Ludwig, Michael McEvoy, David K. Tan, Kyle L. Thornton, Kevin Smith, Bryan R. Wilson

The National Association of EMS Physicians and the then National Association of State EMS Directors created a position statement on emergency medical vehicle use of lights and siren in 1994 (1). This document updates and replaces this previous statement and is now a joint position statement with the Academy of International Mobile Healthcare Integration, American Ambulance Association, American College of Emergency Physicians, Center for Patient Safety, International Academies of Emergency Dispatch, International Association of EMS Chiefs, International Association of Fire Chiefs, National Association of EMS Physicians, National Association of Emergency Medical Technicians, National Association of State EMS Officials, National EMS Management Association, National EMS Quality Alliance, National Volunteer Fire Council and Paramedic Chiefs of Canada.

In 2009, there were 1,579 ambulance crash injuries (2), and most EMS vehicle crashes occur when driving with lights and siren (L&S) (3). When compared with other similar-sized vehicles, ambulance crashes are more often at intersections, more often at traffic signals, and more often with multiple injuries, including 84% involving three or more people (4).

From 1996 to 2012, there were 137 civilian fatalities and 228 civilian injuries resulting from fire service vehicle incidents and 64 civilian fatalities and 217 civilian injuries resulting from ambulance incidents. According to the U.S. Fire Administration (USFA), 179 firefighters died as the result of vehicle crashes from 2004 to 2013 (5). The National EMS Memorial Service reports that approximately 97 EMS practitioners were killed in ambulance collisions from 1993 to 2010 in the United States (6).

Traffic-related fatality rates for law enforcement officers, firefighters, and EMS practitioners are estimated to be 2.5 to 4.8 times higher than the national average among all occupations (7). In a recent survey of 675 EMS practitioners, 7.7% reported being involved in an EMS vehicle crash, with 100% of those occurring in clear weather and while using L&S. 80% reported a broadside strike as the type of MVC (8). Additionally, one survey found estimates of approximately four “wake effect” collisions (defined as collisions *caused* by, but not *involving* the L&S operating emergency vehicle) for every crash involving an emergency vehicle (9).

For EMS, the purpose of using L&S is to improve patient outcomes by decreasing the time to care at the scene or to arrival at a hospital for additional care, but only a small percentage of medical emergencies have better outcomes from L&S use. Over a dozen studies show that the average time saved with L&S response or transport ranges from 42 seconds to 3.8 minutes. Alternatively, L&S response increases the chance of an EMS vehicle crash by 50% and almost triples the chance of crash during patient transport (11). Emergency vehicle crashes cause delays to care and injuries to patients, EMS practitioners, and the public. These crashes also increase emergency vehicle resource use through the need for additional vehicle responses, have long-lasting effects on the reputation of an emergency organization, and increases stress and anxiety among emergency services personnel.

Despite these alarming statistics, L&S continue to be used in 74% of EMS responses, and 21.6% of EMS transports, with a wide variation in L&S use among agencies and among census districts in the United States (10).

Although L&S response is currently common to medical calls, few (6.9%) of these result in a potentially lifesaving intervention by emergency practitioners (12). Some agencies have used an evidence-based or quality improvement approach to reduce their use of L&S during responses to medical calls to 20-33%, without any discernable harmful effect on patient outcome. Additionally, many EMS agencies transport very few patients to the hospital with L&S.

Emergency medical dispatch (EMD) protocols have been proven to safely and effectively categorize requests for medical response by types of call and level of medical acuity and urgency. Emergency response agencies have successfully used these EMD categorizations to prioritize the calls that justify a L&S response. Physician medical oversight, formal quality improvement programs, and collaboration with responding emergency services agencies to understand outcomes is essential to effective, safe, consistent, and high-quality EMD.

The sponsoring organizations of this statement believe that the following principles should guide L&S use during emergency vehicle response to medical calls and initiatives to safely decrease the use of L&S when appropriate:

- The primary mission of the EMS system is to provide out-of-hospital health care, saving lives and improving patient outcomes, when possible, while promoting safety and health in communities. In selected time-sensitive medical conditions, the difference in response time with L&S may improve the patient's outcome.
- EMS vehicle operations using L&S pose a significant risk to both EMS practitioners and the public. Therefore, during response to emergencies or transport of patients by EMS, L&S should only be used for situations where the time saved by L&S operations is anticipated to be clinically important to a patient's outcome. They should not be used when returning to station or posting on stand-by assignments.
- Communication centers should use EMD programs developed, maintained, and approved by national standard-setting organizations with structured call triage and call categorization to identify subsets of calls based upon response resources needed and medical urgency of the call. Active physician medical oversight is critical in developing response configurations and modes for these EMD protocols. These programs should be closely monitored by a formal quality assurance (QA) program for accurate use and response outcomes, with such QA programs being in collaboration with the EMS agency physician medical director.
- Responding emergency agencies should use response based EMD categories and other local policies to further identify and operationalize the situations where L&S response or transport are clinically justified. Response agencies should use these dispatch categories to prioritize expected L&S response modes. The EMS agency physician medical director and QA programs must be engaged in developing these agency operational policies/guidelines.
- Emergency response agency leaderships, including physician medical oversight and QA personnel should monitor the rates of use, appropriateness, EMD protocol compliance, and medical outcomes related to L&S use during response and patient transport.

- Emergency response assignments based upon approved protocols should be developed at the local/department/agency level. A thorough community risk assessment, including risk reduction analysis, should be conducted, and used in conjunction with local physician medical oversight to develop and establish safe response policies.
- All emergency vehicle operators should successfully complete a robust initial emergency vehicle driver training program, and all operators should have required regular continuing education on emergency vehicle driving and appropriate L&S use.
- Municipal government leaders should be aware of the increased risk of crashes associated with L&S response to the public, emergency responders, and patients. Service agreements with emergency medical response agencies can mitigate this risk by using tiered response time expectations based upon EMD categorization of calls. Quality care metrics, rather than time metrics, should drive these contract agreements.
- Emergency vehicle crashes and near misses should trigger clinical and operational QA reviews. States and provinces should monitor and report on emergency medical vehicle crashes for better understanding of the use and risks of these warning devices.
- EMS and fire agency leaders should work to understand public perceptions and expectations regarding L&S use. These leaders should work toward improving public education about the risks of L&S use to create safer expectations of the public and government officials.

In most settings, L&S response or transport saves less than a few minutes during an emergency medical response, and there are few time-sensitive medical emergencies where an immediate intervention or treatment in those minutes is lifesaving. These time-sensitive emergencies can usually be identified through utilization of high-quality dispatcher call prioritization using approved EMD protocols. For many medical calls, a prompt response by EMS practitioners without L&S provides high-quality patient care without the risk of L&S-related crashes. EMS care is part of the much broader spectrum of acute health care, and efficiencies in the emergency department, operative, and hospital phases of care can compensate for any minutes lost with non-L&S response or transport.

Sponsoring Organizations and Representatives:

Academy of International Mobile Healthcare Integration
American Ambulance Association
American College of Emergency Physicians
Center for Patient Safety
International Academies of Emergency Dispatch
International Association of EMS Chiefs
International Association of Fire Chiefs
National Association of EMS Physicians
National Association of Emergency Medical Technicians
National Association of State EMS Officials
National EMS Management Association
National EMS Quality Alliance
National Volunteer Fire Council

References:

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4. Ray AF, Kupas DF. Comparison of crashes involving ambulances with those of similar-sized vehicles. *Prehosp Emerg Care*. 2005;9(4):412-415.
5. U.S. Fire Administration. Firefighter fatalities in the United States in 2013. 2014. Emmitsburg, MD.
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Joint Position Statement on EMS Performance Measures Beyond Response Times

Douglas F. Kupas, Matt Zavadsky, Brooke Burton, Chip Decker, Robert Dunne, Peter Dworsky, Richard Ferron, Joseph Grover, Daniel Gerard, Joseph House, Jeff Jarvis, Sheree Murphy, Jerry Overton, Michael Redlener, George Solomon, Andrew Stephen, Randy Strozyk, Marv Trimble, Thomas Wieczorek, Kathryn Wise

Emergency Medical Services (EMS) exist to provide safe and effective out-of-hospital medical care to communities. Historically, response time has been the primary measure used to assess the performance of an emergency medical services (EMS) system/agency. Public policymakers have adopted response time because it is objective, quantifiable, and easily understood, however, this standard is derived from the need to respond quickly to cardiac arrest and time-sensitive conditions. While it is essential to continue to monitor and promote effective response, the majority of 911 EMS responses do not require a response time under ten minutes[i]. Reliance solely on response time performance increases the cost of EMS and the risk of EMS vehicle crashes. It also prevents communities from evaluating other EMS system quality measures that demonstrate system effectiveness for patient care, experience, and outcomes.

This joint statement encourages EMS systems and community leaders to implement an approach to EMS system performance that prioritizes patient-centered care and uses a broad, balanced set of clinical, safety, experiential, equity, operational, and financial measures to evaluate the effectiveness of EMS systems.

This statement is endorsed by the Academy of International Mobile Healthcare Integration, American Ambulance Association, American College of Emergency Physicians, American Paramedic Association, Center for Patient Safety, International Academies of Emergency Dispatch, International Association of EMS Chiefs, International City/County Management Association, National Association of EMS Physicians, National Association of Emergency Medical Technicians, National Association of State EMS Officials, National EMS Management Association, National EMS Quality Alliance, National Volunteer Fire Council and Paramedic Chiefs of Canada. These associations recommend that local communities and governments modernize the assessment of the performance of their EMS systems/agencies by evaluating a broad array of domains with key performance indicators (KPIs) that can be measured and trended over time, and whenever possible, benchmarked with comparable EMS systems, or other national data, and published to local community stakeholders on a regular basis. The domains that communities should consider when evaluating an EMS system/agency are:

- **Effective**: Is the health care provided clinically appropriate and high quality?
- **Safe**: Are services being provided in a way that is clinically and operationally safe for patients, responders, and the community?
- **Satisfying**: How do patients and EMS clinicians feel about the service being provided?
- **Equitable**: Is the system providing care that is equitable based on patient demographics and service area geography?
- **Efficient**: Is this service being provided in a way that maximizes the use of economic and operational resources?

Whenever feasible, evidence-based performance measures should be used that are associated with improved patient outcomes and system performance. Resources are cited in the attached table that can help to guide selection.

It is also essential for government and community leaders and decision-makers to consider all elements of the EMS system from the moment a 9-1-1 call is made to the conclusion of care by the EMS system/agency.

Innovative programs such as mobile integrated healthcare/community paramedicine, alternative response models and response dispositions to enable a broader array of services to patients and communities should be considered.

By considering these additional performance measures, local communities can gain a more comprehensive understanding of the effectiveness of their EMS system/agency, identify areas for improvement in patient care, system efficiency, and overall emergency response capabilities.

FINAL approved by Named Associations 4/9/24

<u>Examples</u> of EMS System Performance Domains and Potential Measures for Consideration

Domain	Potential Type of Measure for Consideration	Source/Benchmark
Clinical	• Out-of-Hospital Cardiac Arrest • STEMI • Stroke • Trauma • Hypoglycemia • Asthma/COPD • Seizures/Status Epilepticus • Invasive Airway Management • Special Mental Health Crisis Management	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies. National EMS Quality Alliance (NEMSQA) published measures. NEMSIS Public Dashboards. Cardiac Arrest Registry to Enhance Survival (CARES) AHA Mission Lifeline Other state, regional, provincial, or other community clinical indicators
Safety	• % of responses and transports using lights and siren (L&S). • Crash rate/100,000 miles. • Job-related injuries/100,000 hours worked. • Job-related illness/100,000 hours worked. • Reviews of all dispatch priority assignments. • EMS recall rate after a non-transport response.	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies. National EMS Quality Alliance (NEMSQA) published measures. NEMSIS Public Dashboards.
Operational	• The number of produced unit hours compared to scheduled unit hours. • Mission failure rate/100,000 miles. • Response time, for high acuity clinical responses, measured from the time the call is placed to a communication center, to the time of patient contact. • QA assessments to insure reliability of prioritization of responses.	Internal agency data trended over time. Benchmarked to comparable EMS systems/agencies.
Experiential	• Patient experience surveys • Hospital experience surveys • First Response Organization (FRO) experience surveys • Personnel engagement surveys • Employee turnover/retention • Emergency dispatcher engagement surveys	Validated, externally conducted patient and provider experience surveys, such as: • EMS Survey Team • Malcolm Baldrige • Press Ganey Alternatively, internal surveys could be conducted by the agency or local jurisdiction.
Financial	EMS system costs and revenues, reported per: • Staffed Unit Hour • Response • Patient Contact • Transport • Dispatch staffing deficits vs. fully staffed periods.	Internal agency data trended over time. Benchmarked to the Academy of International Mobile Healthcare Integration (AIMHI) survey of EMS systems, or other national data sources.

**These examples are not meant to be all-inclusive; communities should establish patient-centric and evidence-based performance measures based on value to their local stakeholders.*

[i] MurrayB, KueR. The Use of Emergency Lights and Sirens by Ambulances and Their Effect on Patient Outcomes and Public Safety: A Comprehensive Review of the Literature. Prehosp Disaster Med. 2017;32(2):209–216.

Measuring Our Community's EMS System

City Commission workshop

City of Battle Creek

March 4, 2025

Introductions

Ron Slagell, President & CEO

Brian Walls, Vice President of Operations

OUTLINE


History of LifeCare & our current EMS system
Response time history
Response times and patient outcomes
Response times and safety
Focus on quality metrics
Patient satisfaction
Proposed changes in City contract

History of LifeCare & our current EMS system

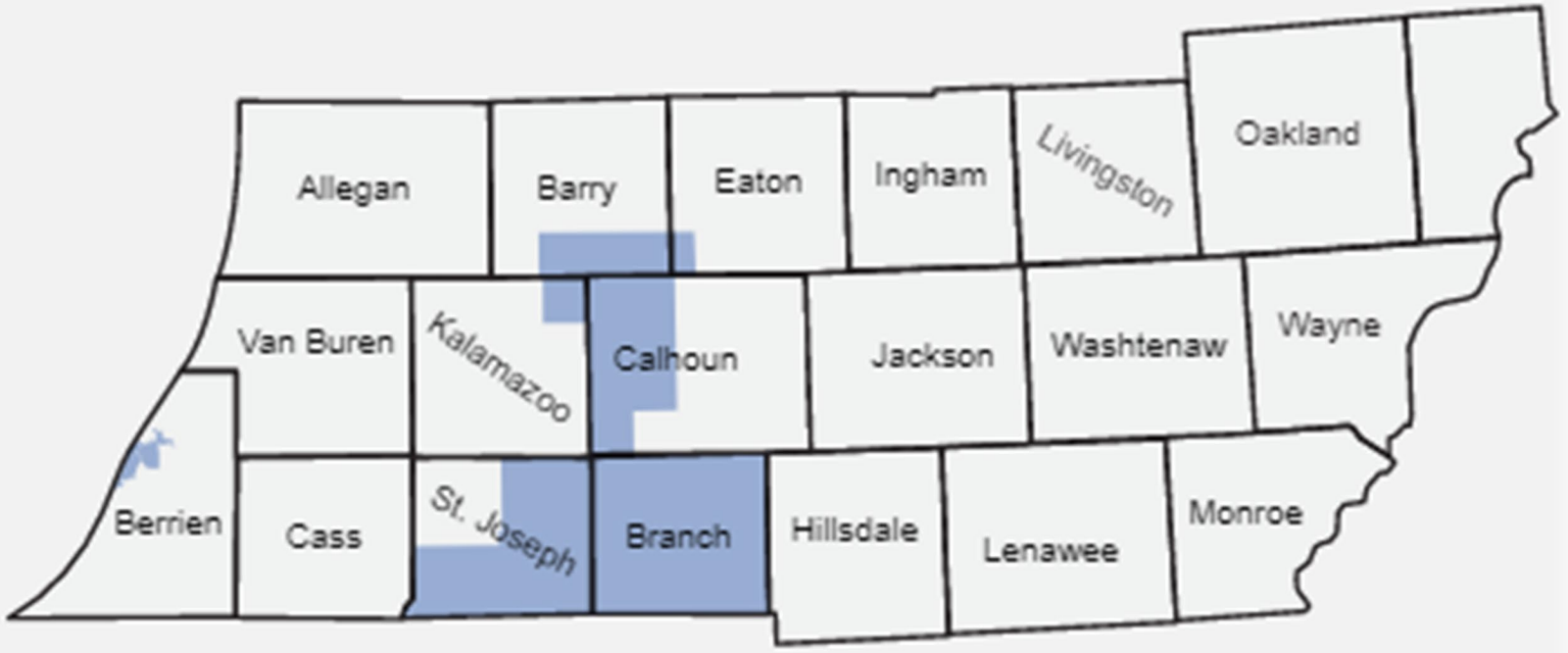
LifeCare Ambulance created in 1983 by the City of Battle Creek and the four area hospitals

Initiated Advanced Life Support (ALS) throughout the City and surrounding townships

Our service area has grown into Barry, Kalamazoo, Branch and St. Joseph Counties

Merged into Emergent Health Partners in 2018

LifeCare Service Area



History of LifeCare & our current EMS system

Not for profit organization

Board of Directors comprised of area residents

Developed a performance-based contract with the City in the late 1980's

Initially had a financial subsidy, but as reimbursement increased from patient's insurers, this was phased out

Battle Creek has one of the largest square mileage of Michigan cities

Our current EMS system

- 9-1-1 calls answered by Calhoun County Central Dispatch
- Battle Creek Fire Department provides Medical First Response
- LifeCare Ambulance provides continuing patient treatment and transportation
  - Advanced Life Support (paramedic)
  - Basic Life Support (EMT)
- Oversight by Calhoun County Medical Control Authority
- EMS Education provided by Kellogg Community College

Response time history

Emergency Medical Services (EMS) began in the 1970's in the US in response to a 1966 federal white paper that outlined how our lack of a system of care was resulting in preventable deaths

The primary focus was on implementing ALS systems (paramedics) and response times

The response time standard relied on was 8 minutes

Derived from 1979 cardiac arrest study that showed benefits of CPR starting within 4 minutes and definitive care within 8 minutes

Response Time History

- What was the most important definitive care in that study?
  - Defibrillation
    - In 1979 could only be provided by paramedics
    - Now can be provided by Medical First Responders, police officers and the general public
- Research has shown the response time of the ambulance does not impact patient outcome in the vast majority of emergencies
    - We can share those research papers with anyone interested

Response times and safety

A 2020 study showed that only 7% of 9-1-1 calls required life-saving interventions, but 86% of those calls had a lights and siren response

Emergency Medical Dispatch is a proven and medically approved method to determine the type and level of response to emergency calls

Calhoun County Central Dispatch effectively utilizes this system

Conditions where minutes matter

- Cardiac arrest
- Respiratory arrest
- Choking
- Life-threatening bleeding

Creating a Tiered Response System

- **Using Emergency Medical Dispatch protocols to define the level and response priority**
  - ALS and BLS
  - First Responder activation
  - Lights and siren response (Priority 1)
  - Immediate response without lights and siren (Priority 3)

Response times and safety

Reducing lights and siren usage when transporting a patient

Our state Medical Director has set a goal of 5% or less

LifeCare’s current utilization is 2.3%

Why Reduce Lights & Siren Reponses

We want to assure we get the patient to the hospital safely.

- Most serious ambulance crashes occur when traveling with lights and siren activated
- Traveling with lights and sirens saves less than 2 minutes and increases the risk of a crash for the ambulance and vehicles in the area

We want to provide the best care that we can.

- Emergency driving causes a more unstable ride for patients and crew.
- Advanced care is most effective with minimal patient movement.
- Siren's increase the anxiety of the patient and may cause their condition to worsen.

Joint Statement on EMS Performance Measures Beyond Response Times-2024

Sponsoring Organizations and Representatives:

- Academy of International Mobile Healthcare Integration
- American Ambulance Association
- American College of Emergency Physicians
- Center for Patient Safety
- International Academies of Emergency Dispatch
- International Association of EMS Chiefs
- International Association of Fire Chiefs
- National Association of EMS Physicians
- National Association of Emergency Medical Technicians
- National Association of State EMS Officials
- National EMS Management Association
- National EMS Quality Alliance
- National Volunteer Fire Council
- Paramedic Chiefs of Canada

Focus on quality metrics

- “Quality care metrics, rather than time metrics, should drive these contract agreements.” – Joint Statement on Lights & Siren Vehicle Operations on Emergency Medical Services Responses (2022)

Focus on quality metrics

- Clinical measures
- Patient Satisfaction
- Safety of the patient and the ambulance crew

How does this information impact our EMS care in Battle Creek

- Moving our response time standard from 8 to 10 minutes for Priority 1 calls
- Working with Central Dispatch, Medical Control, and our First Responders to eliminate lights and siren responses to calls where it is not needed
- Utilizing Basic Life Support ambulances to respond and transport low acuity patients
  - This leaves ALS units more readily available for high acuity patients
  - Follows medical care practices by hospitals and physician offices
  - Clinical quality measures added as metrics

Reference Documents

Joint statement on lights and siren response

Joint statement on EMS performance measures beyond response times

EMS1 article from October

Questions?

Chief Insights: Leadership, culture and continuous growth

Legislation and Funding

EMS on life support: The alarming gap between expectations and reality

It is time for an honest conversation about response times, reimbursement and funding solutions for the future of EMS

October 14, 2024 09:38 AM • AIMHI

The gap is straining EMS systems nationwide.

DALL-E

By Richard ("Chip") H. Decker, III, President, AIMHI

What should you expect when you call 911 for ambulance? For decades, the expectation has been to see an ambulance racing down the street with lights flashing and sirens blaring as Paramedics and Emergency Medical Technicians (EMTs) rush to the scene of a medical

emergency. In reality, time is a factor in a small percentage of the calls EMS respond to and a large portion of calls to 911 today aren't for medical emergencies. The idea of fast equates with quality was pushed by the Emergency Medical Services (EMS) profession, as some emergencies, such as cardiac arrests and strokes, depend on rapid responses for the best outcomes. While time is a factor for these emergencies, they make up a small number of EMS responses. Still, EMS response times are what many localities look to as the key measure of the success of their EMS system with the expectation that all calls to 911 are emergencies and need a quick response. EMS today plays a larger role in healthcare and emergency preparedness, often providing services for which there is no compensation. The gap between expectations and reality has strained EMS systems nationwide, impacting response times, financial sustainability, staffing and patient care. If the gap between expectations and reality isn't closed, the problems facing EMS and the essential service it provides to the public could hit a breaking point. In some places, it already has.

Recently, a joint statement from national and international healthcare and civic organizations called on localities to modernize how they measure an EMS system's success beyond response times. While speed is helpful in some cases, in most responses it can do more harm than good. A 2020 study published in the National Library of Medicine, looking at nearly 6 million calls from almost 1,200 agencies across the country, showed less than 7% of 911 calls for EMS dealt with potentially life-saving interventions even though lights and sirens were used to respond to calls 86% of the time. Another study published by the National EMS Quality Alliance found it was more dangerous to the crews, patients and the public to use lights and sirens that often. In reality, fast does not equate with quality for most 911 calls. EMS systems are being evaluated and sometimes replaced because of an outdated metric. We must ask ourselves, are we doing what's best for patients or changing for the sake of change in hopes ambulances

will arrive more quickly?

> We should be measuring patient outcomes, how successfully staff are providing appropriate treatment according to the latest research and guidelines and when it is truly a factor, response times.

At its inception, the expectation was EMS would be used for medical emergencies. In today's reality, EMS is a catchall. Many EMS responses aren't for emergencies and sometimes do not require any medical assistance at all. At times, patients could be better served with a visit to an urgent care facility, a virtual visit with a doctor, or a response from a behavioral health professional or social services. Research published earlier this year, looking at nearly 2 million EMS responses, found 27% of the responses fell into this category. As call volume for these types of calls has increased, many EMS agencies have been stretched thin. As a result, callers get angry when an ambulance doesn't arrive in minutes.

What is most troubling, is sometimes it is the patients who are suffering a life-threatening emergency that are having to wait longer. If we aren't amplifying and using options more appropriate for patients than a call to 911, we are putting those who need lifesaving help at risk.

In February, a bipartisan group of legislators in Minnesota declared an "EMS Emergency," asking for a $120 million infusion to address short-term funding challenges and strain on current EMS systems, with providers saying EMS in the state was on the brink of collapse. An industry media tracker has identified thousands of media reports on the economic crisis in EMS nationwide.

The reimbursement and funding models for EMS need to be restructured so agencies have access to consistent federal, state and local funding and are paid for services beyond the transportation of patients.

Additional funding is essential but we must also reset expectations so they're more in line with reality. Failure to change will lead to more expensive alternatives, could result in lower quality care and could drive any current and future EMS employees away from the profession. That's where we are headed if we do not close the gap between expectations and reality. We know the problems, now is the time for all of us to have an honest conversation about the solutions.