The “Level Zero” Crisis in Broome County

The Increasing Frequency of “No On-Duty Ambulances Available” for EMS Calls

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Executive Summary - October 4, 2019

The Issue

The demand for ambulance response in Broome County has, with increasing frequency over the past few years, surpassed the supply of staffed (“on-duty”) ambulances. This imbalance between supply and demand can be attributed to multiple factors on both sides of the equation.

The Effects

- Delays in ambulance response to emergency calls of all severity levels, including the most critical (calls must be “wait-listed” until ambulances free up from previous calls).
- Excessive use of mutual aid, depriving (often rural) areas of their own local EMS coverage

Supply Factors

Staff Shortages:

- Continuation of long-term decline in volunteerism
- Challenges in recruitment and retention of career EMS staff, especially as the improving economy has offered better-paying alternatives
- Elimination by NYS of the second-highest level of EMS provider certification

Severe Revenue Limitations - Inhibit ambulance services from increasing pay and/or benefits to counter the foregoing challenges, and make it difficult to meet other increasing costs:

- “Payer mix” of health insurance coverage in the community largely dictates rates of reimbursement. Medicaid, in particular, pays well-below the services’ actual costs.
- Failure of many insurers to pay directly to the ambulance service leads to revenue loss.
- Low call volumes make it difficult for rural services to earn adequate revenue.
- Lack of taxpayer subsidy from most municipalities

Demand Factors

Increasing Rates of Ambulance Utilization:

- Aging population, increasing rates of poverty, increasing violence and addiction, and lack of access by many to primary healthcare and more appropriate means of medical transport.
- Decentralization of healthcare has increased reliance on EMS for inter-facility transportation.

Potential Solutions

Via a multi-disciplinary panel established by the County EMS Advisory Board:

- Establish a percentage of expected call volume that an ambulance service should be staffing to meet, and assist those who are not to obtain the resources needed to do so.
- Re-defining the standards of EMS care to be flexible in response to supply shortages, which will facilitate the conservation of ambulance resources
- Coordinating inter-facility transports with 9-1-1 system call volume to avoid competition for ambulance resources.
- Explore alternative means for handling the lowest-priority calls, and/or a safe and equitable system for “wait listing” them until system demand eases.

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Preliminary Report and Recommendations to the Broome County EMS Advisory Board

Raymond M. Serowik, NRP, CIC – Broome County EMS Coordinator

October 1, 2019

Introduction – The Emergency Medical Services system of Broome County has a rich and diverse history, each agency having emerged and evolved to meet the changing needs and expectations of the communities it serves. These agencies, however, have been increasingly negatively impacted by factors both unique to and transcending Emergency Medical Services, almost all of which have similarly affected our counterparts across this state and nation. The net result of this impact has been the increasing occurrence of so-called “level zero” events, during which the system becomes completely depleted of available staffed (“on-duty”) ambulances, necessitating extraordinary measures to cover these calls, which can include:

- Excessive reliance on mutual aid assistance, particularly that which must respond over a considerable distance, extending response times well beyond the norm for the communities affected, and depriving other communities (often rural ones, without reliable nearby assistance of their own to call upon) of the EMS coverage that they expect and which they may, in many cases, have subsidized with their tax dollars.
- “Queuing” or “wait-listing” calls until such time as ambulances become available after completing their previous calls. While this is not “beyond the pale” with respect to lower-priority calls (particularly “Omega” and “Alpha”-priority calls), it is highly undesirable, and potentially dangerous, with respect to those of the highest priority.

While neither of these measures is highly unusual from a global perspective, they have until relatively recently been fairly seldom employed locally. In fact, a true “level zero” event, in which there are literally “zero” staffed ambulances available from *any* agency whose crew status is tracked by the Broome County 9-1-1 Center, was, for most of recent history, a “very few-times-a-year” occurrence. That, however, has been rapidly changing, and these events are now regularly occurring, as often as several times in a week, with the trend being solidly in the direction of further increase.

The purpose of this report is to open a broad discussion on this matter, to include representatives of as many stakeholder groups as possible, among these being all varieties of ambulance service providers, their allied emergency responders (non-transporting EMS first response agencies, law enforcement agencies, and fire/rescue services), receiving hospitals, local government, and EMS consumers (both individuals and healthcare institutions that utilize EMS for inter-facility transfers). Not only do all of these have a vested interest in reducing and managing “level zero” events, they may well also possess insight and perspective that, when put together, will greatly assist in accomplishing these goals. By means of this document, I ask that the EMS Advisory Board appoint an multidisciplinary expert panel to examine this matter in all of its aspects, and to work together in creating a consensus document describing measures that may be taken by policy makers to assure the continued effective operation of our EMS

system in the face of this escalating challenge. In the spirit of catalyzing a robust and thorough exploration and discussion of these matters, I offer you the following analysis of my own:

The Nature of a “Level Zero” Event – Fundamentally, a “level zero” event is an imbalance between the readily-accessible supply of ambulances at the level(s) of care required, and the simultaneous demand for them both within our County and within those areas of adjacent counties that are primarily covered by ambulance services based in our County, or which receive mutual aid assistance from those services. Limitations in supply and surges in demand combine with increasing frequency to produce this imbalance, and both sides of this “scale” bear careful examination when searching for solutions.

Incidence – It is difficult to precisely quantify the incidence of “level zero” events affecting Broome County, as no reliable mechanism has yet been developed to memorialize them. Management of the Broome County 9-1-1 is currently engaged in an effort to utlilize certain tools within the computer-aided dispatch system to reliably “flag” these events for individual analysis and overall enumeration. Few, however, would dispute the premise that these have become much more frequent in recent history, particularly those of us who must directly manage their effects.

FACTORS OF LIMITED SUPPLY

Our EMS system, of course, has *never* enjoyed an unlimited supply of staffed ambulances, but for most of its history the supply has been adequate to more-than-adequate most of the time. So, what has changed?

Almost everyone is aware that our system was once staffed predominantly with volunteers. From the 1970s, when volunteers replaced ambulance services previously provided by law enforcement agencies, to the mid-1980s, when formerly all-volunteer agencies gradually began to add paid staff, only two local ambulance services (Superior Ambulance, and the City of Binghamton – first the Police Department and later the Fire Department) were staffed with compensated personnel. It is well-known that EMS volunteerism reached its peak locally in the early-to-mid 1980s, before beginning a gradual-but-steady decline that continues to this day. Global factors, such as the increase in two-earner and single-parent families, the loss of jobs that allowed volunteers to work in or near the communities in which they lived (and volunteered), as well as of the large employers that often-released employees from work (with pay) to cover ambulance calls, and a general generational trend away from volunteering in the emergency services, have all contributed to this decline. Almost no one now seriously believes that there is any real possibility of reversing this trend to any significant extent.

Despite the steady decline in volunteerism, the mainly not-for-profit ambulance services that once relied exclusively on volunteers have effectively continued operations through the increasing use of compensated staff, and over the past three decades EMS has become a viable full-time career for an increasing number of people locally. Even this, however, is encountering serious challenges in recent years. Particularly since the rebound in the national economy, fewer people, especially young people, are choosing careers in EMS. Those that do typically hold two or more EMS positions (a full-time, and one or more part-time or per-diem), in order to meet both the demand for providers (particularly at the ALS levels), and their own income and benefits aspirations. As a result, an increasing percentage of the EMS workforce, at any given time, is either on-duty or is enjoying an infrequent day-off from which they are

unwilling or unable to be recalled by any of their EMS employers to "surge" the system in response to spikes in demand.

The inevitable and decisive shift toward compensated staff has naturally limited the number of staffed ambulances that any given agency can field, due to straightforward economics:

Limited Revenues - Simply put, ambulance agencies are on a "fixed income", determined in major part by:

- Call Volume – since almost all of our system's ambulance services operate on a fee-for-service basis, the agencies receive little or no income unless their ambulances are answering calls. From an EMS agency perspective, a "perfect" balance between staffed ambulances and call volume would be for all of its staffed ambulances to be continuously busy, with calls spaced evenly, end-to-end, so that all of the agency's calls-for-service can be covered by its own units, and the units experience no "down time" other than that necessitated by report writing, restocking, and an occasional well-deserved meal. This, of course, is not reality, and there are often hours of "down time" followed by multiple, simultaneous calls that exceed the number of staffed units that the agency has available. When the agency cannot quickly increase the number of staffed units through the recall of off-duty personnel and/or the utilization of administrative personnel, the call must be covered under the County Mutual Aid Plan by another agency (if available), and the revenue generated by that call (if any – see the following section) is therefore lost to that agency. Thus, the "art" of ambulance staffing is to "right-size" the number of on-duty units to match, as closely as possible, the "normal" expected call volume, so that both the amount of unproductive "down time", and the number of calls (and attendant revenue) lost to other agencies, are minimized.

- "Payer Mix" – The "payer" refers to the entity that will provide the payment-for-service for an ambulance call. It will be a private insurer for those fortunate enough to be covered by such a program through their employer; "no-fault" auto insurance payment for those injured in a motor vehicle or auto-vs.-pedestrian collision; a public insurance program such as Medicare (for the elderly/retired), Medicaid (for the poor), or in some cases both; or "self-payment" for those without health insurance coverage (typically the "working poor" who make too much money to qualify for Medicaid, but do not have employer-sponsored health insurance). Each of these programs (except "self-pay") sets the rates at which ambulance services will be compensated, based upon the level of service (BLS, ALS, transport mileage) provided. By law in New York State, an ambulance service *must* accept the insurance payment, *plus* any patient co-payment specified in the insurance contract, as *payment-in-full*, and may *not* bill the patient (or anyone else) for the difference between that and the ambulance service's "usual and customary" rate for the level of service provided. Rates vary widely by payer, with private health insurance and no-fault auto insurance typically paying the most, Medicare somewhat less, and Medicaid paying very poorly (well below the ambulance agency's own costs for providing the service). While those on self-pay status are technically liable to pay the full amount billed by the service, they are seldom capable of doing so ("you can't get blood from a stone"), and even aggressive collection actions are rarely successful (even if the patient can be located, which is often not the case). "Payer mix" refers to the overall distribution of insurance coverage in the community covered by an ambulance services, and thus to the amounts and rates-of-payment that it typically receives for its service. It is apparent, therefore, that ambulance services covering more affluent communities, with

higher rates of private insurance coverage, will typically realize higher revenue collections, while those covering poorer communities will fare much less well.

- ”Assignment” – Health insurers work to reduce their cost by enticing providers into their “networks”. In exchange for accepting lower rates of reimbursement, insurers will pay providers directly (called “assignment” of payment). Should a provider (including an ambulance service) decline to join a network, that insurer will typically send payment to the patient rather than to the provider, and, sadly, a significant number of patients will “pocket’ the insurance payment and “stiff” the ambulance service. Only very aggressive collection efforts, which cost the ambulance service both money and good will in the community, are typically successful in recovering the payment in such circumstances.

- Municipal Subsidy (or Lack Thereof) – In addition to payment-for-service, as outlined above, some ambulance agencies are fortunate enough to receive some level of taxpayer funding to subsidize the cost of their operations. Sadly, this is *not* the majority of services, and for good reason: no level of municipal government in New York State has any legal obligation to provide, or to pay for any part of, ambulance services for its community, and many choose not to, even if they formerly did. The reasons are many, including the already much-higher-than-national-average property tax rates in New York, and the pressure to remain below the state-imposed “tax cap”. Some agencies, however, have been fortunate enough to receive a significant level of subsidy from their local government(s). These are mainly rural agencies whose governments have been convinced that subsidy is the only means by which their communities can hope to receive an adequate-level of locally-based ambulance service.

Increasing Costs – Compounding the effects of “flat” revenues are those in escalating costs:

- Labor – EMS as a “third service” (outside of the career municipal Fire Service) has never had a reputation for being exceptionally well-compensated. With a tightening labor pool, however (especially with respect to ALS providers), this has begun to change. This trend has been accelerated by New York State’s decision, in 2018, to “sunset” the long-standing EMT-Critical Care level of certification. It is now no longer possible to produce new EMT-CC providers, and Paramedics (and the dwindling-number of previously-certified EMT-CCs) are therefore the only full-service ALS providers remaining. Demand for these providers is high, and employers are increasingly challenged to increase pay rates and/or benefits to recruit and retain them. This, coupled with the factors of revenue limitation previously outlined, make it abundantly clear why some EMS agencies are no longer able to field enough crews to meet the increasing demand.

- Other Costs – As almost everyone knows from their own life experience, the cost of vehicles, insurance, utilities, fuel, supplies, services, etc. etc. are almost constantly increasing. Even though many are exempt from sales and property taxes, they are not exempt from market forces and inflation. Cost increases often outrun revenue increases (if there ever are any), further limiting ambulance service capabilities to field staffed ambulances.

FACTORS OF INCREASING DEMAND

It is demonstrably true that the per-capita demand for EMS services has increased remarkably over the past four decades. To illustrate, I offer you my own personal experience:

I answered my first ambulance call in 1977, when the *resident population* of the town served by the ambulance service I then belonged to exceeded 75,000, and many thousands more who did not live in the town commuted there each weekday to work in the many thriving industries that were located there. In all likelihood, the peak weekday population exceeded 100,000 persons! How many ambulance calls did my then-service received that year? I remember it well: just over 3,000! (Call rate = 1 call/25 residents/year). Fast-forward to 2018. The population of that same town was just 53,251 (U.S. Census Bureau estimate as of 7/1/18). Much of the industry is gone, and *many* fewer therefore commute in to work in the town each day. How many calls did that same service receive *only within the town* in 2018? 8,016! (Call rate = 1 call/6.64 residents/year) What could possibly account for such an increase in call rate over 40 years? Let's consider:

- Aging Population – Although historical data for comparison are difficult to find, it is well-accepted that the median age of the population in Upstate New York has been steadily increasing over the past few decades, as younger people have tended to leave the region for other areas of the nation in pursuit of economic opportunity that is lacking here. The remainder of the population is consequently older, on average, and getting more so, especially since Americans in general are living longer. An older population means increased healthcare needs, including those for EMS services and the other healthcare outlets that EMS "feeds".
- Decentralization of Healthcare – As mentioned, remarkable progress in healthcare is resulting in longer life, on average, and that healthcare has become increasingly diverse. No longer are all services found within the walls of a hospital, with homecare, outpatient clinics, and skilled nursing facilities serving as the conduits for many of them. When the inevitable crises occur at these non-hospital locations, or when an increasing number of patients at local hospitals must be transferred to specialty services in larger cities, EMS is called upon at all hours of the day and night, and in all kinds of weather, to supply the needed transfer care and transportation. Calls to walk-in clinics, primary care practices, nursing homes, and local hospitals have become a daily routine for many of our local ambulance services. These agencies generally welcome these calls, because, among other reasons, payment is often guaranteed and made by the sending institution (which is in turn reimbursed by insurers in a "bundled" fashion), making these calls an important and reliable source of much-needed revenue.
- Less Self-Reliant Population – As business and industry has left Upstate New York, so have many well-paying jobs. As the median income has accordingly decreased, so too has the ability of much of the population to "fend for itself". Many, especially among the poor, lack access to private transportation to meet their healthcare needs, and many also lack access to primary healthcare. These factors may combine to make EMS an accessible "one-stop-shop" for both entry into the healthcare system and transportation to same. "When 9-1-1 is called, someone always shows up".
- Crime, Violence, and Addiction – As poverty contributes to unmet healthcare needs, so it also contributes to crime and violence. Even the perception of being unsafe in one's neighborhood may increase reliance on EMS as a "safe" means out in a perceived crisis, and certainly the injuries received as a victim of crime often call for EMS care. The epidemic of addiction and overdose has also, notoriously, contributed to the demand for EMS services in our communities.
- The Hazards of Youth – Even an economic "bright side" of our County has its pitfalls! As we have evolved into a vibrant university community, health crises inherent to young adulthood have placed increasing demands on our EMS system, particularly on weekend nights!

Surges in calls have occurred, both on-campus and at those off-campus locations frequented by students and other youth. This is seen perhaps most acutely on “parade day”, which occurs annually on the first Saturday of March.

It is acknowledged here that the foregoing lists of supply and demand issues are not exhaustive, and that others are likely to emerge if and when the requested panel convenes to study the matter.

POTENTIAL “SOLUTIONS”

These lists may at least help clarify that many of the factors contributing to the “level zero crisis” are broad and societal, and that their “solutions” (if there are any) are well beyond the scope or capability of any EMS system. Still, it is incumbent upon us as an EMS system to manage their effects and mitigate their negative impacts upon our patient population, to the best of our ability. It is in this spirit that the following are offered as “conversation starters” toward a positive, consensus-based, and comprehensive plan arrived at through the combined efforts of all stakeholders:

Ambulance Agency Responsibility – Where do EMS calls tend to occur? The short answer is: “where the people are”. Thus, the most urbanized areas of our County predictably see the greatest concentrations of calls for EMS service. It stands to reason, then, that they would also enjoy the highest levels of ambulance resources to meet those demands, but this is not strictly so. Urban areas also typically have among the least-desirable “payer mixes” (poor rural areas also falling into this category), making it difficult-to-impossible to fund a consistently-adequate level of staffed unit availability without substantial municipal subsidy. In the case of at least one service that provides a large percentage of coverage to the “urban core” of our County, there is no municipal subsidy. Instead, it appears that the service may rely on a robust inter-facility transport business to help offset the poor payer mix likely associated with its 9-1-1 responses. The increasing frequency of such business, as previously noted, may however be competing with those 9-1-1 calls for their available units. Even some of our suburban areas, where payer mix tends to be much better, suffer from a lack of municipal subsidy and consequent inability to fund a level of staffing adequate to consistently meet the “normal and expected” demand for service in their primary service areas.

Whatever the demographic and funding sources, the inability of an ambulance agency to consistently meet its “normal and expected” call volume with its own resources has a negative cascading effect on the rest of the system. We have always had a robust mutual aid system in our County, with most agencies unhesitatingly making most or all of their staffed resources (including whatever resources they can “surge” in times of exceptional demand) available to assist their neighbors as needed. Some of these “mutual aid” exchanges, however, are highly asymmetrical, and at least one major ambulance agency is not officially a party to the County EMS Mutual Aid Plan. In these times of increasing demand and level-to-contracting supply, this would seem to be unequitable and in need of correction and reform in short order.

It would seem reasonable for the multidisciplinary panel to “benchmark” what, in our system, constitutes an “adequate” level of EMS staffing, based on call volumes, frequency, and other relevant factors. Agencies that do not consistently meet this standard with respect to their primary response areas could then be assisted by the group in formulating a strategy for doing so. This could include anything from formulating a business case to their local government for the establishment or increase of subsidies, to perhaps the exploration of more sustainable

operational models than their present one (e.g.: merging with one or more other agencies). Whatever strategies are arrived at by the panel, agencies that consistently present themselves as “conspicuous consumers” of mutual aid resources, without a substantially-symmetrical contribution of such resources, should be expected to avail themselves of them, and to make steady progress toward remediation.

Standards of Care – In the early 1990s, the Susquehanna Regional Emergency Medical Advisory Committee (SREMS REMAC) issued a policy to the effect that “ALS care must be sent, at the time of initial dispatch, on any call in which it can be reliably determined from caller information that it is needed”. This policy coincided with the adoption of Emergency Medical Dispatch (EMD) systems by most local dispatch centers, making it feasible in most cases to accurately identify such calls. In the ensuing 25 years, our system has been overwhelming successful in meeting the demand for ALS response created by this policy, but again, as previously noted, things are changing (most acutely with regard to ALS staffing).

Agencies that cannot sustain adequate levels of ALS staffing to meet “normal and expected” demand must compensate by increasing their use of BLS providers and units. Reallocating available ALS providers to non-transporting “fly car” vehicles, capable of “chasing” or “intercepting” the BLS ambulances and supplementing the care they have already begun, may provide the additional degree of flexibility needed by many agencies to “right-size” care to each patient’s need, and to avoid unnecessarily “tying up” ALS providers when BLS care is appropriate. These “fly cars” were once a common feature of ambulance agencies when staffing was mostly or completely volunteer, allowing the then-limited number of ALS providers to respond only when needed, and allowing the then-plentiful BLS providers to handle all of the calls they could. They fell substantially into disuse as agencies began to staff their ambulances with paid ALS providers, obviating the need for fly cars. Their time may now be returning.

Too often, calls dispatched at the ALS level have ended up consuming twice the resources that they should, with the local (“first-due”) ambulance agency providing a transporting BLS ambulance, and ALS being provided by a second agency (taking an entire ALS ambiance from that agency “out-of-service” for the duration of the call). It would seem like “low-hanging fruit” in addressing this problem to eliminate as many of these “double-consumption” scenarios as possible.

In March 2012, the National Institute of Medicine first published *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, introducing the concept that medical standards of care *must* change in times of exceptional circumstances, if the most good is to be accomplished for the greatest number of those impacted. Since then, this concept has become well-accepted in all aspects of medicine, and it now may be time to introduce it into discussion with respect to the present “crisis”.

Ideally, all prehospital EMS care would be provided by a Paramedic, or perhaps even better by an Emergency Medicine Physician or even a specialist, but we know that this cannot be so in the real world. Instead, we must provide care to the “right” level when we can, or, failing that, to the best that we can otherwise do. We must never lose sight of the fact that that the hospital emergency department is *always* a source of ALS care for the patient, and that, given system conditions at times, it may in fact be the *closest* source of ALS available, as long as the patient receives *expedient* BLS care and transport there. Yet this is seldom practiced any more. As ambulance agencies “retool” to fielding more BLS units, they must educate and empower their EMTs to evaluate, in all relevant cases, whether the ED may be the closest available source of

ALS, and to move the patient rapidly there when conditions indicate. These agencies must then support and stand behind these decisions when they are reasonable and made in good faith, and with the patient’s best interest at heart.

We must be mindful, as well, that the capabilities of the EMT are vastly enhanced over those of 30 or 40 years ago, when the great “push” for prehospital ALS began. AEDs, CPAP, nebulizer treatments, injected epinephrine, blood glucose determination, naloxone, and 12-lead ECG acquisition and transmission are all modalities readily available for use at the EMT level, and which address many of the most pressing life and health threats in ways that used to be available only through ALS. The availability of the “new” AEMT level of certification and practice (which has been referred to as “enhanced BLS”), adds intravenous and intraosseous access, epinephrine in cardiac arrest, and advanced airway management of adults to this changing picture. The once-rigid BLS / ALS dichotomy is no longer in place. With this in mind, it may be time for the REMAC to revisit its almost 30-year-old policy, to allow greater flexibility for EMS systems to spare ALS resources in less-acute ALS-indicating complaints (e.g.: “Charlie” level) preserving them for the more-acute (e.g.: “Delta” and “Echo” level) calls.

With respect to those calls that “prioritize” as BLS from the start, it would seem advisable to send a BLS-staffed ambulance instead of an ALS-staffed ambulance, whenever reasonably possible. When I rode along with NYC EMS in 1982, that system fielded about three-times as many BLS ambulances as ALS, and it was a fairly *rigid* rule that the system did not expend ALS ambulances on BLS calls, even when those calls had to wait (within carefully-set limits) for a BLS ambulance to free-up from a previous call. Such system resource management principles may indeed have a place in a local system “redesign” in response to dwindling ALS staffing.

Low-Acuity Calls – We have always known that “all EMS calls are not created equally”, yet we usually treat them as through they were. In the face of an impending “level zero” event, it would seem ludicrous to send our last (or next-to-last) ALS ambulance on an “Alpha” (or even “Omega”) level lifting assistance call. Yet we often do exactly that. It would seem feasible, during times of high system demand, to “wait-list” such-low priority calls (or better yet, to adopt alternative means of handling them that do not involve ambulance response – unless the alternative responders arrive and determine it to be necessary). I would urge that guidelines for such situations be part of any system redesign recommendations by the panel.

Interfacility Transports – Many interfacility ambulance transports are unquestionably necessary and even urgent, and nothing should be done to interfere with or delay those that are. Others are not, however, and it would seem feasible to coordinate those with current conditions within the 9-1-1 system, to assure that vitally-needed resources are not being diverted from the latter at a time of high-demand. It would also seem advisable to ask local healthcare organizations to comprehensively review their ambulance utilization policies, in the light of a heightened understanding of how they may be impacting the community-at-large. Are all ambulance transports from primary care and walk-in clinics really necessary, or can at least some of those patients receive the care that they need at those locations, perhaps enhanced by telemedicine consultations with ED physicians and/or specialists? These are questions that should be explored by and with our hospital and other healthcare partners, in the context of the problem that we are currently addressing.

Conclusion – It is an understatement to say that “we are all in this together”. In addition to our respective roles in the EMS and/or the larger healthcare system, each of us, as well as our loved ones, is a potential future EMS patient. We all, therefore, have a vested interest in making

certain that our EMS system remains functional under *all* demand conditions. It has been many years we have had any major change in the way our EMS system functions, and to my knowledge (and I would know), it has *never* had a comprehensive examination intended to modernize it in response to changing conditions. Again, I respectfully ask the Broome County EMS Advisory Board, by official resolution, to establish a multidisciplinary panel to comprehensively study this matter, and to make a report back to the full Advisory Board for its consideration for adoption and submission to all relevant policymakers.

I look forward to working with this panel, if it should please the Advisory Board to create it, in decisively addressing the problems, as well as the potential solutions, outlined in this document.

Respectfully,

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