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Fall 2026

A PUBLICATION OF THE CALIFORNIA AMBULANCE ASSOCIATION

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The California Ambulance Association website has a wealth of valuable information available to you, including a Membership Directory, a CAAPAC page, Stars of Life, CAASE, and CARESTAR Foundation Awards, an up-to-date Calendar of Events, online meeting registration, archives of important and timely articles and legislative updates in back issues of *Siren* magazine, and a Members-Only section.

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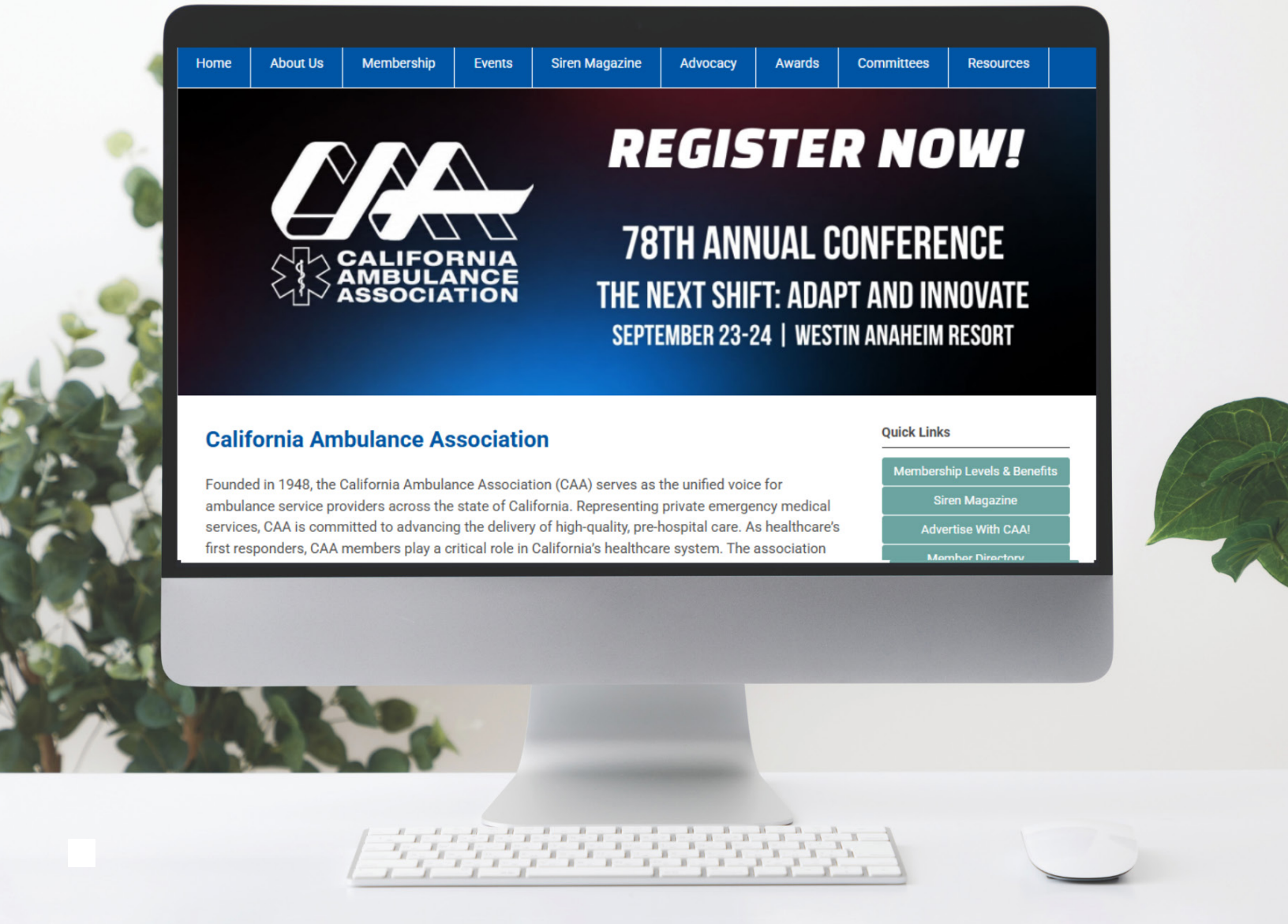

CAA Siren

Fall 2026

A PUBLICATION OF THE CALIFORNIA AMBULANCE ASSOCIATION

CAA Vision

To champion the leadership, advocacy, education, and tools that empower California's private ambulance and mobile healthcare services to provide people-centered EMS systems and standards. The CAA's overarching role is to provide support for those who care for their communities.

CAA Mission

Be a recognized voice, advocate, and authority of best practices for ambulance providers throughout California.

CAA Leadership

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Circulation among California's private ambulance providers, elected officials and EMSA administrators.

PRESIDENT'S MESSAGE

Back to School: Will We Choose Fear or Curiosity?

Steve Grau
President
California Ambulance Association

This issue of Siren arrives just ahead of our annual conference. Students are heading back to school. The rest of us should probably dust off our backpacks, too.

Last week, I helped my oldest daughter, Nicole, move into her freshman dorm at CU Boulder.

As a proud parent, it was exciting, chaotic, and bittersweet. Students and families carried optimism and anxiety into unfamiliar buildings, imagining a future they could not fully see.

Life has given me plenty of opportunities to practice letting go. That practice served me well that day. It reminded me that growth, for our children and for ourselves, requires releasing some control and learning to trust what comes next.

Inside a very small dorm room on a 90-degree Colorado day, we unpacked boxes, rearranged furniture, and made the space functional. We were setting the stage for growth without knowing what it would look like.

Standing there, I kept thinking: Maybe back to school is not just for students.

Artificial intelligence is already changing how we work, communicate, solve problems, and develop our careers. Some people see extraordinary possibilities. Others see risk and disruption. I understand both reactions. What we cannot afford is sitting this one out.

Our greatest limitation may not be the technology. It may be our willingness to learn, adapt, and lead through uncertainty.
For EMS leaders, education and upskilling cannot remain side projects for whenever operations slow down. We all know operations never slow down. Learning has to become part of the work.

That does not mean every leader needs to become a technologist. It means we need enough understanding to ask better questions, use sound judgment, and help our teams navigate change responsibly.
Where do we begin? Not with another strategic plan. With practice.

Choose one tool and use it consistently. Ask it to challenge your thinking, identify blind spots, or help build a roadmap. Listen to people doing the work. Experiment with real problems inside your organization. Then share what worked, what did not, and what surprised you.

None of us will keep pace alone. We need colleagues, educators, industry partners, and fellow experimenters willing to compare lessons and learn together.

That is why CAA launched its Technology & AI Collaborative. We are bringing EMS leaders, technology partners, developers, and data experts into the same conversation. We are not gathering to chase every new platform or pretend we have all the answers. We are here to understand what is useful, responsible, and capable of genuinely improving the work. Leaders should create the same environment inside their organizations. Make room for

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PRESIDENT'S MESSAGE – *continued from page 2*

experimentation. Reward curiosity. Bring in expertise when you need it, while building your own team's capability for the long term.

Nicole did not arrive on campus with every answer. She arrived ready to discover what she did not yet know. Maybe that is the mindset the rest of us need right now.

Fear and curiosity can both walk into the room. Our inner work as leaders is recognizing both, then choosing which one gets to lead.

I invite you to bring that curiosity to our annual conference, engage with the Technology & AI Collaborative, and help shape a CAA that keeps learning, evolving, and leading together.

Class is already in session.

EXECUTIVE DIRECTOR'S REPORT

Adapt and Innovate: Looking Forward, Building on Momentum

Rob Lawrence
Executive Director
California Ambulance Association

As we gather in Anaheim for the California Ambulance Association's 78th Annual Conference, our theme, **The Next Shift: Adapt and Innovate**, could hardly be more appropriate. EMS is entering a period of significant change, and this conference is deliberately designed to look forward. We want to be something of a crystal ball into what comes next: not pretending we can predict every development, but bringing together the people, ideas and technologies that are already beginning to shape the future of our profession.

Artificial Intelligence is clearly part of that future, and we are leaning into it. Across the conference you will hear about AI in clinical care, operations, documentation, quality improvement, revenue cycle management and leadership. But we are deliberately balancing **AI with EI — Emotional Intelligence**. We can have all the computers, algorithms and automation we want, but ultimately, we still need humans leading humans. Technology may make us faster, smarter and more efficient, but empathy, judgement, communication, curiosity and leadership will remain distinctly human responsibilities. Our challenge is not to choose between people and technology, but to understand how each can make the other better.

And then there is **RI — Reimbursement Intelligence**. There is nothing particularly futuristic about the need to get paid for the work we do, but the environment in which we do so becomes more complicated every year. Reimbursement remains the lifeblood of our organizations. Understanding payers, documenting correctly, navigating regulation, identifying lost revenue and advocating for sustainable funding are fundamental to maintaining the readiness our communities expect. AI, EI and RI therefore provide three useful lenses through which to view this conference — technology, people and sustainability.

> **"AI, EI, and RI therefore provide three useful lenses through which to view this conference — technology, people, and sustainability."**

While Anaheim gives us an opportunity to look forward, it is also worth looking back at what CAA has accomplished over the past several months. Reading through our Weekly Word updates since June provides some perspective on the sheer volume and breadth of activity underway across the Association. We have completed the transition to a new Association Management Company, moving from CAMS to Impact Association Management while maintaining continuity of Association business and simultaneously building this Annual Conference. We have launched a new Technology and AI Collaborative, continued the work of our Operations, HR, Education, Membership and Engagement, Legislative and reimbursement groups, and maintained regular Town Halls and member communications. Our committees have addressed issues ranging from DEA controlled-substance requirements, TB screening and continuing education compliance to wage-and-hour law, workplace AI, documentation, employee engagement, cybersecurity and interoperability.

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Our advocacy work has been equally active. **AB 1328**, our Medi-Cal ambulance reimbursement legislation, has progressed through the Legislature, including passage through Senate Appropriations, while CAA members have responded to repeated calls to action supporting our effort to secure the associated funding. **AB 2372**, addressing toll-road exemptions for private ambulances, passed the Senate and moved back to the Assembly for concurrence, while **AB 2041**, concerning pre-arrival instruction compliance, has continued its progress. Alongside those bills, the Legislative Committee and our regulatory working groups have been engaged on AB 40 implementation, EMSA Chapter 1 regulations and the wider ambulance RFP environment.

There has also been substantial work that may attract fewer headlines but directly affects members: engagement with DHCS over provider revalidation problems; guidance through the GEMT Average Commercial Rate Survey; implementation of the California Data Exchange Framework; monitoring Medicare, Medi-Cal, Medicare Advantage and VA reimbursement changes; employment law updates; federal advocacy; and the continuing exchange of operational best practices between members. We have also opened the 2026 CAA Service Excellence Awards, continued development of *Siren*, and substantially expanded the educational and networking opportunities available through the Association.

That combination of looking forward while doing the work required today is perhaps the best description of **Adapt and Innovate**. Innovation is not simply about adopting the newest technology. It is about building stronger organizations, developing better leaders, protecting sustainable reimbursement, learning from one another and being prepared to change when the environment around us changes. So, welcome to Anaheim. Enjoy *Siren*, enjoy the conference, challenge our speakers, question our experts, meet somebody new and bring your own experience to the conversation. The future of EMS is not something that will simply happen to us.

We have an opportunity to help shape it.

> **"The future of EMS is not something that will simply happen to us. We have an opportunity to help shape it."**

With Gratitude for the Time, Attention, and Engagement

Advocacy work is built on persistence, but it is also built on listening. As part of our work on AB 1328 and broader ambulance reimbursement reform, CAA is deeply grateful to the many public leaders, advisors, consultants, and agency officials who have taken time to meet with us, hear our concerns, ask hard questions, and engage thoughtfully with the realities facing California's ambulance providers. In several cases, these were not one-time conversations. They were repeat meetings and continued discussions, reflecting a genuine willingness to learn, examine the issue more deeply, and help us navigate the path forward.

- **Assembly Speaker Robert Rivas** and his office
- **Rosielyn "Roz" Pulmano**, Health Advisor to Speaker Rivas
- **Assemblymember Dawn Addis**, Chair of the Assembly Budget Subcommittee on Health
- **Patrick Le**, Consultant to the Assembly Budget Subcommittee on Health
- **Senate President pro Tempore Monique Limón** and her office
- **Marjorie Swartz**, Health Advisor to Pro Tem Limón
- **Senator Caroline Menjivar**, Chair of the Senate Budget Subcommittee on Health
- **Scott Ogus**, Consultant to the Senate Budget Subcommittee on Health
- **Richard Figueroa**, Health Advisor to Governor Gavin Newsom
- **DHCS Director Michelle Baass**
- **Guadalupe Manriquez**, Program Manager for Health at the Department of Finance

We do not take these meetings for granted. Real progress begins with attention, grows through dialogue, and moves forward when leaders are willing to listen and wrestle with the facts. ✱

Impact

ASSOCIATION MANAGEMENT

Intro to Impact AMC

Impact's Story

Impact is a full-service association management provider with over 20 years of experience delivering strategic, transparent, and innovative management solutions for medium-sized professional associations, professional societies, trade associations, and foundations.

Impact is a boutique firm, large enough to offer deep, specialized skillsets yet small enough where clients have access to C-Suite. At Impact, every client matters, and every client is incredibly valued. The Impact team prides themselves on developing great relationships with their clients so leadership and members truly enjoy partnering with them.

Client Experience

Impact has worked in a wide variety of organizational structures, industries, and sizes. That broad range of experience means each staff member is well-rounded, knowledgeable, and prepared to apply their experience to serve the strategic efforts of every organization they work with.

Impact has successfully partnered with many associations in growing membership, managing financials, supporting board operations, executing marketing campaigns, holding successful meetings and events, implementing efficient and goal-driven processes, and more.

On average, Impact's association clients see a 55.96% increase in membership and an average 89.6% membership retention rate (2024) as compared to the median membership renewal rate for U.S. professional societies of 81% (according to the MGI 2023 Membership Marketing Benchmark Report).

Connect with Impact

CAA members can reach out to CAA team members from Impact by calling our office at (916) 239-4095, or emailing info@the-caa.org for general questions or membership-related inquiries. Questions about upcoming events should be sent to events@the-caa.org. Impact team members will also be onsite at the Annual Conference and look forward to meeting our members, vendors and attendees.

Going Beyond Satisfactory: Why Extraordinary Service Matters in EMS

Barbara Khozam

In the world of emergency medical services, every second counts. But beyond the clinical expertise and technical protocols, there's another factor that can shape the outcome of every call: the quality of the service experience. Too often, we focus solely on getting the patient to the hospital or resolving a crisis—forgetting that each interaction, however brief or tense, is an opportunity to create trust and loyalty in ways that matter long after the sirens fade.

Why does extraordinary service matter in EMS? Because our patients and their families are at their most vulnerable when they need us. Their anxiety is high, their sense of control is low, and they will remember not only what you did, but how you made them feel. I've seen firsthand— across thousands of healthcare and service organizations—that a single moment of empathy or a well-timed word of reassurance can turn a stressful event into a story of gratitude and relief.

Extraordinary service is not about grand gestures. It's about consistently executing a handful of small, intentional actions: making eye contact, introducing yourself by name, listening without interruption, and communicating clearly—especially in difficult moments. These behaviors may sound simple, but they're the difference between being seen as just another provider and being remembered as a hero.

Too often, organizations treat customer service as an afterthought. They focus on technical performance and compliance, but neglect the training and culture-building needed to empower staff to deliver genuine care and connection. The result? Patient complaints, low morale, and missed opportunities for loyalty. I've watched companies lose business—not because they failed to deliver on the basics, but because they failed to make people feel important.

But when EMS teams commit to a process—a simple, four-step workflow for extraordinary service—everything changes. Staff feel more confident, patients feel more respected, and even complaints become moments to build trust rather than destroy it. In my work, I've seen organizations raise satisfaction scores and reduce turnover simply by adopting a service-first mindset.

It all comes down to culture. When leaders model the behaviors they want to see, reward positive interactions, and give staff the tools to handle even the most difficult customers with grace, extraordinary service becomes the norm, not the exception. This is not just about making people happy—it's about operational excellence and the reputation of your organization.

In EMS, you have the power to shape how your community sees you. Every call is a chance to either build your reputation or break it. What story will your patients tell about their experience with you? The difference between a routine encounter and an extraordinary one is often just a single, intentional act of service.

Optimizing Employee Benefits for Ambulance Companies: Strategies for a Diverse Workplace

Heffernan Insurance Brokers

Ambulance employers have a unique and diverse workforce, often characterized by a low average age and a predominance of male employees. This demographic presents an opportunity to tailor programs specifically for those populations while also addressing the needs of Baby Boomers and Generation X employees. Additionally, ambulance companies often experience higher turnover rates compared to other industries, with employees transitioning to roles such as paramedics, firefighters, nurses, physician assistants, and other healthcare-related positions.

When evaluating your Employee Benefit Package, consider these strategies to support your unique workforce:

SELF-FUNDING MEDICAL AND DENTAL INSURANCE:

Given the low average age and high proportion of young males, self-funding options can be advantageous for ambulance employers. Young males typically use healthcare services less frequently, leading to fewer claims. In a self-funded model, employers can benefit from cost savings if claims are lower than the total premium. Similarly, self-funding dental insurance is becoming more popular, offering employers a chance to reduce costs and improve cash flow, with savings realized if utilization is below expectations.

WORKSITE PRODUCTS (VOLUNTARY LIFE, LONG TERM DISABILITY, HOSPITAL INDEMNITY, ACCIDENT, CRITICAL ILLNESS):

Due to the demanding and potentially dangerous nature of the job, offering worksite products can protect employees and their families from worst-case scenarios, such as job-related injuries. These benefits enhance employee satisfaction and retention by providing valuable financial protection and wellness options, contributing to a more engaged and productive workforce.

WAITING PERIOD CONSIDERATION:

Employers can also consider adjusting the waiting period for benefits. Implementing a longer waiting period before new hires can access certain benefits ensures that only committed employees receive these perks, reducing costs associated with high turnover. This strategy allows companies to invest more in training and development for employees with long-term potential, thereby enhancing overall service quality.

MAXIMIZE EDUCATION ON EMPLOYEE ASSISTANCE PROGRAM (EAP) BENEFITS:

Due to the Emergency Ambulance Employee Safety and Preparedness Act requiring employers to offer 10 mental health sessions. While required, this is a great benefit for employees, which is often extremely underutilized. Building an annual plan with flyers, emails, and in-person education can increase utilization and ideally reduce burnout and stress. Additionally, make sure you're marketing the EAP program to different carriers/vendors.

BOOST AWARENESS OF EMPLOYEE ASSISTANCE PROGRAM (EAP) SERVICES:

Take advantage of the Emergency Ambulance Employee Safety and Preparedness Act's requirement for 10 mental health sessions by promoting and educating employees on the benefit. Create an annual action plan with flyers, emails, and in-person education to boost utilization and reduce burnout.

BENEFIT EDUCATION BASED ON GENERATIONS

- **Gen Z:** Responds best to honest and open communication from HR and managers, expansive voluntary benefits offerings, and guidance on planning for financial and physical well-being.

- **Millennials:** Value frequent feedback on performance, open communication lines with HR and managers, and multi-platform communications about benefits offerings and open enrollment.

- **Gen X:** Prefers casual information sessions, benefits that help build a secure future, and information on retirement.

- **Boomers:** Appreciate straightforward language on benefits programs, financial scenarios over conversations, and messages about conserving and passing on wealth to the next generation.

By implementing these strategies, ambulance companies can effectively support their diverse workforce and enhance overall employee satisfaction and retention. Please feel free to reach out to me if you have any questions or need further assistance

EMS Needs Mass Advocacy: My Journey from the Field to National Leadership

Marshall Woodmansee | Royal Ambulance

Marshall Woodmansee is a Communication & Policy Coordinator at Royal Ambulance, where he focuses on government affairs, strategic communications, and workforce advocacy. He came to the role through an unconventional path, from running for office as a young adult, to the field as an EMT, to finding his footing at the intersection of EMS and public policy. He spoke on mass advocacy at the American Ambulance Association's 2026 annual conference. He can be reached on LinkedIn.

I never expected to find myself giving a presentation on grassroots advocacy in emergency medical services.

But last week that's exactly what happened. I stood in front of national EMS leadership at the American Ambulance Association's annual conference in Las Vegas and made the case that our industry needs community organizers as much as it needs clinicians and lobbyists.

I'm still kind of amazed I was there.

How I Got Here

Hi, my name is Marshall Woodmansee.

My journey in EMS started two years ago when I joined Royal Ambulance as an EMT, fresh out of college, with plans to become a paramedic firefighter. Within my first week of field training I came down with a serious health condition, unrelated to work, that effectively ended my clinical career before it started.

After recovery I reached out to Royal looking for a way to stay connected to the work. They found one. I started part time in a growing Government Affairs department, and a year ago that became a full time role that now includes employee engagement and external communications.

It's a lot of hats. But there's a through line.

Before EMS, There Was Politics

Before EMS I was in politics. I ran for San Jose City Council at age 18 and for mayor of San Jose at 21, one of the largest cities in the country. Those weren't resume builders. I ran because I genuinely believed, and still believe, that my generation has inherited a set of challenges that demand new kinds of leaders from new kinds of backgrounds. Climate change. Housing. Transportation. Economic instability. I showed up to those races not knowing if I'd win, but knowing I had something to say.

EMS was supposed to be a different kind of showing up. Fewer speeches, more action. Turns out the two aren't as separate as I thought.

What Working in EMS Policy Taught Me

Working in EMS policy opened my eyes fast. The workforce is burning out. Reimbursement rates haven't kept pace with the actual cost of care. Agencies are understaffed and underresourced at precisely the moment when demand is accelerating. More aging adults. More frequent disasters. More gaps in the healthcare system that ambulances are quietly filling every single day.

The Case I Made on Stage

But here's what I got up on that stage to say. The problem isn't only resources. It's that not enough people are fighting loudly enough for those resources. EMS needs mass advocacy. Organized, coordinated, sustained public pressure from providers, patients, and community members who understand what's at stake and are willing to say so out loud.

That's the presentation. Watch it on YouTube here.

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What I Couldn't Fit Into Six Minutes

What I couldn't fit into six minutes and forty seconds is the part that actually excites me most. I don't think EMS is just a broken system that needs fixing. I think it's a framework the world is going to need more of.

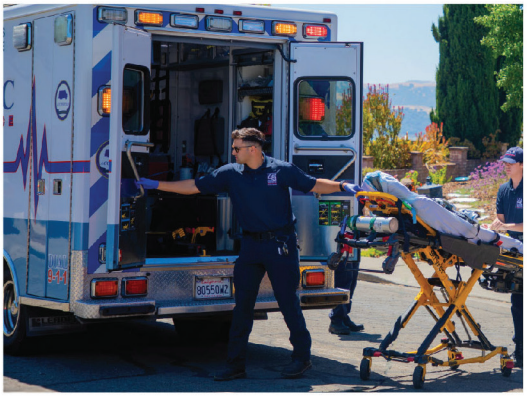
A system that goes where the problems are, trains people quickly, delivers care outside clinical walls, and shows up in the hardest moments. Disaster response. Community medicine. Rapid workforce development. These aren't peripheral functions. They're exactly what an era of compounding crises demands.

What Comes Next

The advocacy work, the communications, the employee engagement work I do at Royal, it's all pointing in the same direction. Building something. I'm not entirely sure yet what it becomes. But this presentation was the beginning of saying it out loud.

If any of this resonates, reach out. Find me on LinkedIn.

There's a lot more to talk about.



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MEDIC
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CARING IS OUR CORE

Dedicated to Excellence. Committed to Care.

For over 45 years, Medic Ambulance has set the standard for exceptional emergency medical services in Northern Californiae. As a family-owned and community-focused provider, we are proud to serve with cutting-edge technology, highly trained professionals, and an unwavering commitment to saving lives and improving patient outcomes.

From 9-1-1 emergency response to interfacility transport and critical care services, Medic Ambulance stands at the forefront of innovation, ensuring our patients receive the highest level of care—when every second counts.

We are honored to be part of the California Ambulance Association and to celebrate the dedication of EMS professionals across the state. Thank you for your service, your passion, and your commitment to excellence.

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CARING IS OUR CORE

Stronger Care with Stronger Systems: The Hidden Network Behind the CAA

Sean Sullivan
President Elect, California Ambulance Association
CEO, LIFEWest

Like (I'm sure most of) you, I entered this profession because of a passion to care for others. This is what motivates us daily, throughout our careers and in our personal life. But what enables our best version of compassionate care is our systems. We all know "good" days happen when behind the scenes, calls are triaged, supplies are restocked, and data flows appropriately, work that's often invisible, but absolutely vital to everything that comes next.

This year, the California Ambulance Association underwent its own kind of behind-the-scenes transition. In June, we welcomed Impact as our new association management group. If you've noticed things running better, that's no accident. The team at Impact has stepped in with energy and precision, ensuring our daily operations (administrative, operational, and financial) didn't skip a beat (pun intended).

Transitions like this are never simple. There's always more under the hood than anyone expects: membership records, finances, event planning, communications, compliance, the (very long) list goes on. The work is detailed, sometimes thankless, and always essential. It reminds me a lot of what we do in EMS: the best days are the ones when nobody notices anything out of the ordinary, because it means everything is working as it should.

But Impact didn't just hop into an in-service ambulance association and keep the engine running. They took on the added challenge of preparing for our annual conference; a heavy lift under any circumstances, but especially so when you're still learning the ropes. Their commitment to best practices, attention to detail, and willingness to go the extra mile has been nothing short of impressive.

In EMS and at the CAA, we talk a lot about best practices and continuous improvement. We know that excellence is never an accident; it's the result of focused effort, routine review, and a willingness to adapt. Association management is no different. The systems and support Impact is putting in place aren't just about making today easier, Impact is focused on building a foundation for the CAA's future.

To our members: your voice, your work, and your commitment to best practice are what make this profession-leading association what it is. But none of it would be possible without the folks and systems working behind the scenes. As we look ahead to our conference and beyond, I want to thank the Impact team for their hard work and invite all of you to join me in welcoming them as partners in our shared mission.

We often say in EMS that the best care is delivered quietly, consistently, and with pride. The same is true for the work that keeps the CAA moving forward. Here's to the next chapter, and to all the people, seen and unseen, who make it possible!

— Sean Sullivan, President Elect

THIS IS NOT JUST A TECHNOLOGY PROBLEM

CAA Technology & AI Collaborative

Steve Grau
President, California Ambulance Association

When the California Ambulance Association launched its Technology & AI Collaborative this summer, we did not begin with a product demonstration or pretend we had the answers. We began by getting the right people into the conversation and asking better questions.

We brought together EMS leaders, technology partners, developers, and data experts to explore where artificial intelligence might create practical value for our industry.

The first discussion surfaced challenges many of us know well: administrative burden, disconnected systems, difficult access to data, responsible AI governance, and the frustrating gap between having information and being able to use it.

One issue kept coming back: interoperability.

Every EMS organization relies on multiple systems. CAD, ePCR, billing, finance, workforce, safety, and analytics platforms each hold a different part of the story. Most were not built to speak with one another.

The burden of connecting those pieces usually falls on our people. Leaders wait for reports. Teams reconcile conflicting information. Someone exports another spreadsheet. We have more data than ever, yet getting a clear answer can still require a small archaeological expedition.

At Royal, we have wrestled with the same question: How do we connect operational, revenue-cycle, and financial information well enough to understand what is happening and decide what to do next?

This is not unique to Royal. It is an industry-wide leadership challenge. During our second Collaborative session, we explored what interoperability actually means and where its absence creates the greatest burden. The conversation was complex, and at times we had to push through competing definitions and perspectives. That was healthy. If the problem were simple, someone would have solved it already.
True interoperability still matters. Our systems need to exchange information reliably and securely. But our discussion surfaced another possibility: We may not have to wait for perfect interoperability to make better use of the information we already have.

AI can provide a practical bridge. Information from separate systems can be responsibly brought together and made easier to explore through plain-language questions and more natural interactions. Instead of navigating five platforms and assembling the answer by hand, a leader could ask a question and receive a useful, traceable view across those sources.

That does not solve interoperability. But it may help us move from fragmented data toward better decisions while the larger infrastructure continues to evolve.

The most important lesson from the Collaborative was not technical. It was about how progress actually happens.

EMS leaders were willing to describe their real problems. Technology partners listened without immediately reaching for a sales pitch. Participants challenged assumptions, admitted what they did not know, and kept working toward common ground.

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This is Not Just a Technology Problem – *continued from page 14*

CAA can play an important role in creating that space. We can bring together the people operating EMS organizations and the people building the tools we depend on. We can test assumptions, learn faster, and keep innovation grounded in the needs of our members and the communities we serve.

Our next step is understanding where members are in their AI journey. Watch for a survey about your current challenges, readiness, and the areas where shared education would be most useful.

This work needs technology leaders, but it cannot belong only to technologists. We need owners, executives, clinicians, dispatchers, operations leaders, finance leaders, and emerging leaders in the conversation.

AI is not simply a technology problem. It is a leadership opportunity involving people, workflow, judgment, trust, and our willingness to change.

Bring us a problem worth solving, a lesson worth sharing, and the curiosity to learn alongside one another. We are still shaping the Collaborative, which means this is exactly the right time to help shape it.

CARLY'S CORNER

The Schedule Was Full... So Why Was Everything Still Broken?

Carly Strong
Chief Operating Officer
Lifeline EMS

One of the easiest traps for EMS leaders to fall into is believing that if the schedule is full, the vacancies are covered, and every ambulance is staffed, then the system must be performing well. After all, those are the metrics we've traditionally watched. If they're green, we assume the operation is healthy.

But experience tells us that's not always true.

Some of the most significant operational challenges don't begin with staffing shortages—they begin with outdated assumptions. An organization can have every shift covered and still struggle with response performance, increasing overtime, employee burnout, holdovers, and rising operating costs. The numbers suggest everything is working, while the people living the operation every day know something feels different.

I've learned that the question shouldn't simply be, *"Are we fully staffed?"* A much more valuable leadership question is, *"Are we deploying the people we have in the smartest possible way?"*

When Yesterday's Success Becomes Today's Constraint

One of the realities of a mature EMS organization is that successful practices gradually become embedded in the culture. Shift start times become tradition. Posting plans become permanent. Deployment strategies that once solved a problem eventually become accepted as "the way we've always done it."

The challenge is that our systems don't stand still. Call volume changes, hospital relationships and transport patterns shift, traffic patterns evolve, and the geographic distribution of our work changes. Even the hours when our system experiences its greatest demand can look very different than they did several years ago.

Yet our schedules don't always evolve with them.

Before long, we can become exceptionally good at maintaining a schedule built for an operation that no longer exists. That's not necessarily a staffing problem. It's a systems problem, and that distinction matters.

Fully Staffed Doesn't Always Mean Correctly Staffed

I experienced this firsthand. We had done what operational leaders are supposed to do: worked hard to stabilize staffing, reduce vacancies and build a schedule we could consistently fill. On paper, the schedule looked good.

But operationally, something still wasn't right.

Our schedule was full, but our resources weren't always aligned with our demand. That realization changed the questions we were asking.

Instead of looking only at how many units were staffed each day, we started looking at when those staffed unit hours were actually available compared with when our calls were occurring. We looked at demand by hour and by area, peak coverage, shift start times, shift lengths, unit start locations, workload, holdovers and overtime. We looked at where our resources were positioned when the system was busiest and, just as importantly, where we had resources sitting later in the day after demand had already begun to fall.

That is a very different analysis than simply asking whether the schedule is full. A staffed ambulance at 2200 doesn't help much if what the system desperately needed was another ambulance at 1600. The employee count didn't change, but the value of the staffed hour did.

Looking Beyond the Dashboard

EMS leaders rely heavily on dashboards, and rightly so. Performance metrics are essential to managing complex operations. The challenge is that dashboards only measure what we've decided to measure.

A report may show every shift filled, acceptable vacancy rates, and adequate daily unit coverage. It doesn't necessarily reveal whether enough of those units are working during your true peak, whether crews are spending too much time crossing the service area, whether

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shift starts still align with current demand, or whether overtime and holdovers are being driven in part by the structure of the schedule itself.
In other words, dashboards measure activity exceptionally well, but they don't always measure alignment.

That became one of the most important lessons for me in this process. A metric can be completely accurate and still not tell you the whole story. A report showing that you're 100% staffed may be completely correct, but leaders still need to ask what exactly they are 100% staffed for.
That's where we have to keep digging.

Stop Asking for More People
When operational performance begins to decline, it's natural to assume the answer is more staffing. Sometimes that's exactly what's required. EMS certainly isn't immune to workforce shortages.

But sometimes we're simply adding resources to a system that no longer matches today's operational reality.

Before assuming we needed more people, we had to understand whether we were getting the greatest possible value from the people and staffed hours we already had. That meant looking at where demand was actually occurring, identifying our true peak periods, understanding how much of our daily staffing was active during those peaks, and determining whether our shift start times created the right amount of overlap.

We also had to look critically at whether we were carrying too many staffed hours beyond the periods when we needed them most, whether unit start locations still made sense, and whether certain schedule patterns were contributing to holdovers, overtime or employee fatigue.

Those questions shifted the conversation away from simply staffing the schedule and toward designing the system. That is where the real opportunity was.

Sometimes the Schedule Has to Move
Once the data tells you the schedule is wrong, the next part is harder: changing it.
Redesigning a deployment model isn't simply an operational exercise. It's an organizational change initiative. New shift patterns affect families, start times employees may have worked for years can change, station assignments move, and daily routines are disrupted. Some employees embrace the change, while others resist it. Some may even decide the new model no longer works for their lives.

We experienced that, and this is where leadership has to be willing to separate discomfort with change from evidence that the change itself is wrong.

That doesn't mean ignoring the impact on employees. Quite the opposite. Schedule changes should be thoughtful, data-driven and deliberate. Leaders should understand what they are asking of their workforce and make adjustments where they reasonably can. But preserving a schedule simply because everyone is accustomed to it isn't a deployment strategy.

Our responsibility is to build a system that supports our patients, our employees and the long-term health of the organization. Sometimes that means changing something that once worked very well.

The Goal Isn't a Perfect Schedule
There's another lesson I've taken from this work: there probably isn't such a thing as a permanently perfect EMS schedule.

Demand, volume, contracts, hospitals, communities and our workforce all change over time. Any one of those changes can affect what the right deployment model looks like, and when several of them change at once, a schedule that once performed exceptionally well can become misaligned without anyone immediately realizing it.

The goal isn't to redesign the schedule once and declare the problem solved. The goal is to build a deployment model that we continue evaluating and adjusting as the operation changes.

That was one of the unexpected benefits of moving toward a more demand-based model. Once we understood why resources were placed where they were and what data supported those decisions, future adjustments became much easier. Instead of protecting a historical schedule, we could respond to what the system was actually telling us.

That's a much healthier place for an operation to be.

The Leadership Lesson
Perhaps the biggest takeaway is that EMS leaders should periodically challenge assumptions that were once correct.

A deployment model that delivered excellent performance five years ago may no longer reflect today's demand. A staffing plan that once balanced workloads may now contribute to burnout. A shift start time that once made perfect sense may now miss the busiest part of the day.

An organization can be fully staffed and still be strategically misaligned. Asking whether you have enough people will always be important, but asking whether you have the right resources, in the right place, at the right time is ultimately the question that separates simply filling a schedule from actually managing a system.

Carly's Corner
Every EMS leader has probably found themselves saying, *"We just need more staff."* Sometimes that's absolutely true. But before you launch another recruitment campaign or authorize another overtime shift, ask yourself one additional question: If someone handed us ten more employees tomorrow, would we deploy them differently than the ones we already have?

TWO NATIONAL AWARDS, ONE MISSION: Medic Ambulance Recognized for Excellence in Integration and Community Health

Medic Ambulance has earned national recognition from the Academy of International Mobile Healthcare Integration (AIMHI), receiving **two prestigious Excellence Awards** that recognize innovation in emergency medical services, patient care, and community health.

The awards were presented during the AIMHI Annual Meeting by **AIMHI President Rob Lawrence**, recognizing two programs that exemplify the organization's mission of advancing integrated mobile healthcare through measurable outcomes and best practices.

Medic Ambulance was honored with the **Excellence in EMS Integration Award** for its partnership with Sonoma County Fire District and the **Excellence in Public Information and Education Award** for the Medic Keep the Beat Foundation.

Together, the awards highlight two complementary aspects of modern EMS: delivering exceptional emergency care through integrated system design while preventing emergencies through proactive community engagement.

Excellence in EMS Integration

The **Sonoma County Fire District–Medic Ambulance Service partnership** was recognized as one of the nation's leading examples of public-private EMS integration. Launched in January 2024 after successfully securing Sonoma County's Exclusive Operating Area, the partnership demonstrates how fire agencies and ambulance providers can operate as a single, patient-centered system.

Today, the integrated model provides more than **30,000 patient transports annually**, including approximately **6,000 Basic Life Support (BLS)** transports that preserve Advanced Life Support (ALS) resources for the most critically ill patients. A unified approach to clinical governance, operational planning, and quality improvement has produced measurable gains in stroke care, STEMI treatment, pediatric documentation, and waveform capnography utilization.

The partnership has also embraced continuous learning, completing the vast majority of clinical reviews within hours of patient encounters while delivering thousands of individualized feedback messages to clinicians. Combined with specialized disaster response capabilities—including an AmbuBus, off-road response vehicles, and integrated command resources—the program demonstrates how collaboration across organizational boundaries can improve patient outcomes while strengthening regional preparedness.

Excellence in Public Information and Education

The **Medic Keep the Beat Foundation**, the nonprofit arm of Medic Ambulance, received AIMHI's **Excellence in Public Information and Education Award** for its work promoting healthier, safer communities through education and prevention.

At the center of the Foundation's work is its **Fall Prevention Program**, which provides free in-home safety assessments and funds home safety modifications for older adults throughout Solano County. Simple interventions such as installing grab bars, improving lighting, and providing durable medical equipment help reduce fall risks, enabling seniors to remain safely in their homes while avoiding preventable injuries and unnecessary 9-1-1 responses.

Working alongside healthcare providers, senior service organizations, first responders, community centers, food banks, and housing communities, the Foundation ensures its services reach those most at risk. The organization also promotes community preparedness through Automated External Defibrillator (AED) donations and public education initiatives that empower residents to respond effectively during medical emergencies.

Its philosophy is simple but powerful: *the best emergency is the one that never happens.*

Setting the Standard

AIMHI's Excellence Awards recognize organizations that demonstrate measurable improvement, innovation, and practices that can be replicated by EMS systems across the country. Receiving two national awards in the same year is a significant achievement and reflects Medic Ambulance's commitment to advancing EMS on multiple fronts.

Presenting the awards, AIMHI President **Rob Lawrence** noted that both programs embody the principles behind the Excellence Awards by demonstrating measurable results, fostering collaboration, and creating models that other EMS systems can adapt to improve patient care and community health.

Whether through integrating fire and ambulance operations into a seamless patient-centered system or preventing emergencies before they occur through education and outreach, Medic Ambulance continues to demonstrate that the future of EMS extends far beyond the ambulance itself.

Stop Leaving Money on the Table: A Private Pay Playbook for EMS Billing Teams

Kelly Parsons-O'Brien | **Owner & CEO, Pacific Credit Services**

Part 1: Why Patient Engagement Is Broken and What It's Costing You

When was the last time your company sat down and really thought about what it feels like to be a patient receiving your bill?

Your crew responded fast. They provided excellent care. The transport went smoothly. And then, weeks or even months later, a bill arrives in the mail from a company name the patient barely recognizes, for an amount that feels like it came out of nowhere, with no explanation of what insurance paid or why there's still a balance. The patient has no idea who to call. And honestly? Neither does your billing team half the time, because patient-pay accounts have been sitting in a stack, waiting for someone to get to them.

This is one of the most common and most avoidable revenue problems in the ambulance industry. Fixing it doesn't require a huge budget or a complete overhaul of your operations. It requires intention.

Why Patient Engagement Keeps Getting Put Off

Between insurance follow-up, claim denials, AB 716 compliance, commercial payer requirements, patient inquiries, appeals, and staffing shortages, there simply aren't enough hours in the day. When resources become stretched, patient communication falls to the bottom of the list. Not because anyone made a conscious decision to deprioritize it. But because insurance billing has hard deadlines, contractual consequences, and immediate financial impact. Patient-pay accounts feel softer. They'll still be there tomorrow. Until one day you look at your aging report and realize how much revenue has quietly walked out the door.

The Structural Problem Nobody Talks About

Many ambulance companies that outsource their billing have unknowingly created a structural gap in their revenue cycle. Third-party billing companies that specialize in EMS are, by design, built for insurance. They are exceptional at navigating Medicare and Medi-Cal requirements, managing commercial payer contracts, and working claim denials. That expertise is genuinely valuable and harder to replicate in-house.

But insurance billing and patient engagement are fundamentally different disciplines. One requires knowledge of payer rules, codes, and contracts. The other requires empathy, communication skill, education, and the ability to have a compassionate conversation about money with someone who just experienced a medical emergency. When an agency assumes the second is covered because the first is outsourced, patient-pay accounts fall into a gap. Statements go out. Patients don't respond. Eventually accounts are sent to a collection agency, often 120 or 180 days after the transport, when the window of goodwill has long since closed.

What Patients Are Actually Thinking

Most patients who do not pay their ambulance bill are not refusing. They are confused. They are thinking things like:

- *"I have insurance. Why do I owe anything?"* Nobody explained that ambulance transport often has separate cost-sharing.
- *"I thought my secondary insurance would cover the rest."* They have no way of knowing what happened because nobody told them.
- *"I didn't even get a statement."* Address changes and outdated records are more common than anyone wants to admit.
- *"I thought an appeal was still pending."* They have been waiting on a resolution that was finalized months ago.

An invoice tells a patient what they owe. It does not often answer any of these questions. When patients have unanswered questions, they do what most of us do with confusing mail: they set it aside. Later becomes never. And a collectible account becomes a write-off.

Research consistently shows that recovery probability drops roughly 10 to 15 percent for every 30 days a patient account goes unworked, and accounts engaged within the first 30 days recover at approximately three times the rate of those left until 180 days. For California ambulance providers already navigating rate pressures and reimbursement challenges, the revenue left on the table from disengaged patient accounts is not a rounding error. It is largely preventable.

Patient engagement does not fall through

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the cracks because your billing team is failing. It falls through the cracks because most EMS organizations have never deliberately built a patient engagement strategy. That is a leadership problem, and it has a leadership solution.

Part 2: Building Your Internal Patient Engagement Process

If a patient called your company right now with a question about their bill, who would answer? Not which phone number would ring, but which specific person in your organization owns that conversation, knows how to handle it, and has the training and confidence to guide that patient toward resolution? If the honest answer is "somewhere in billing" or "whoever picks up," you have identified the root of your patient engagement problem.

Assign a Real Owner

Patient engagement needs a named owner inside your organization. Not a department. Not a shared responsibility. A person whose job description explicitly includes proactive outreach to patients with open balances. Critically, that person should not be simultaneously working a denial queue or chasing insurance claims. Those two functions compete for attention, and insurance work almost always wins. Patient accounts need someone whose entire focus, even if only for designated hours each day, is the patient.

That owner is responsible for:

- Initiating outreach within 15 days of statement issuance.
- Answering questions about what insurance paid and what options are available.
- Identifying accounts where missing insurance or an appeal opportunity exists.
- Offering and documenting payment plans for patients with financial hardship.
- Escalating accounts appropriately when internal engagement is exhausted.

Train for the Conversation, Not Just the Transaction

When someone receives an unexpected ambulance bill, they are often still processing the medical event itself. They may be in what we describe as fight or flight mode: overwhelmed, anxious, and defensive before you say a single word. That context changes everything about how you approach the call.

At PCS we use a framework called F.L.O., which stands for First, Last, and Only. Every patient contact should be treated as if it is the first time that patient has spoken to anyone about this bill, the last opportunity you may have to reach them, and the only chance to make a good impression. Train your staff to let patients hear them smile. Telephone image, the impression your staff creates in the first few seconds of a call, sets the tone for everything that follows.

Effective training builds five core skills:

- ***Communication style and tone.*** Warm and confident, not urgent or transactional.
- ***Active listening.*** Let the patient explain fully before responding. Simple affirmations like "I see" signal presence without interrupting.
- ***Empathy.*** "I realize this has to be frustrating for you" and "I'd be upset too" are not concessions. They are connection points.
- ***Asking for clarification.*** Reflect back what you heard to keep the conversation collaborative.
- ***Asking for payment with confidence.*** "Would you be able to take care of that balance today, or would a payment plan be more helpful?" The ask has to actually happen.

Also eliminate negative words from your scripts entirely. "No," "not," "can't," "won't," "however," and "unfortunately" are conversation closers. Replace them with solution-forward language: instead of "I can't waive that balance," try "What I can do is set up a payment plan that works for your budget." The information is identical. The experience is completely different. And when a patient becomes angry, remind your team of the QTIP principle: Quit Taking It Personally.

Build a Contact Cadence and Measure It

A cadence is a defined sequence of outreach at specific intervals so no account ages invisibly:

- **Day 1 to 5:** Plain-language statement with a direct phone number and payment option.
- **Day 14 to 21:** First proactive outreach call or text to confirm receipt and answer questions.
- **Day 30:** Second statement and follow-up call.
- **Day 45 to 60:** Final internal outreach with payment plan options prominently offered.
- **Day 60 to 90:** Evaluate for escalation. This is a strategy, not a failure.

Track leading indicators alongside collections data: days to first patient contact, contact rate within 30 days, resolution rate by age bucket, and payment plan take rate. By the time a bad collections number shows up in your report, the damage from poor patient engagement happened 90 to 120 days ago.

Part 3: Knowing When to Call for Backup

There is a moment every EMS billing manager knows. You look at your aging report and see accounts that have been sitting there for 60, 90, maybe 120 days or more. Your team has sent statements, made calls, left voicemails. And the accounts just keep aging.

When accounts are old enough that internal recovery rates are declining with every passing week, and your team is stretched thin enough that spending

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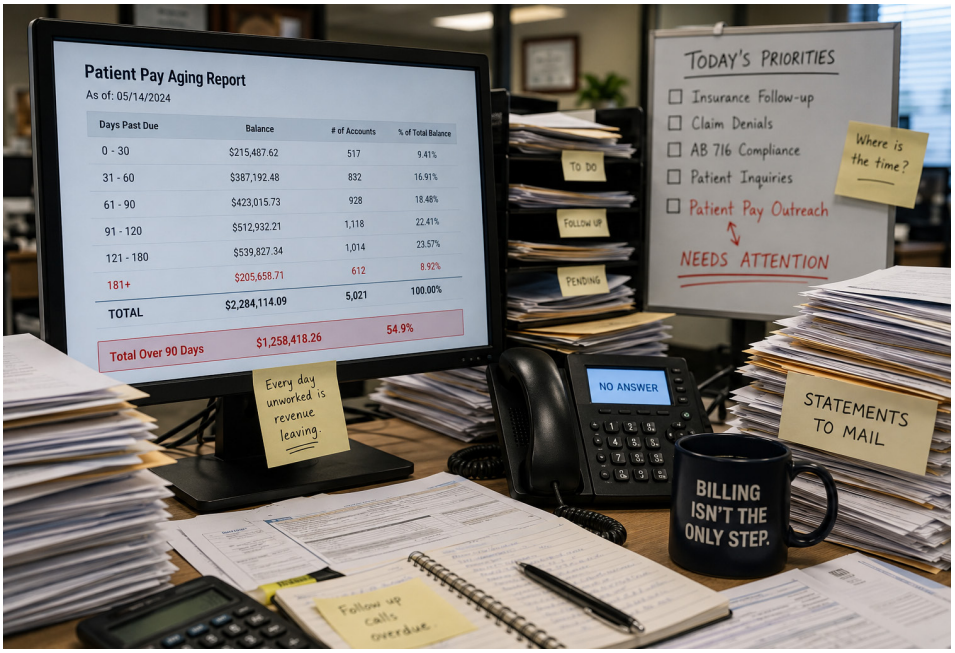


more time on these accounts means something else is not getting done, that combination is your signal. It is time to bring in an outside partner.

Rethinking What an Outside Partner Actually Does

The word "collections" carries baggage. For many EMS administrators, it conjures images of aggressive phone calls and damaged patient relationships. That perception reflects an outdated model. The most valuable outside partners today are patient communication specialists who happen to be experts in account resolution. And the best among them offer early-out first-party programs, which is where the real difference is made.

In a traditional third-party model, accounts are placed after internal efforts are exhausted, often at 90 to 180 days. The agency contacts patients under their own name, which signals escalation and puts patients on the defensive. In an early-out first-party program, accounts are placed much earlier, often at 30 to 60 days, and the partner contacts patients on behalf of your company, using your name and your brand. The tone is helpful and educational. The goal is resolution. Early-out programs consistently outperform traditional bad-debt placement because they catch patients while goodwill and contact information are still intact.

What to Look for in a Partner

Choosing the wrong partner is worse than choosing no partner at all. Here are the non-negotiables:

- ***Healthcare and EMS specialization.*** A partner who does not understand the ambulance billing environment or California's regulatory landscape will confuse your patients rather than help them. Ask about their EMS client base and tenure in healthcare collections.
- ***Patient-centered communication standards.*** Ask how they train their staff. Ask what their escalation process looks like when a patient becomes upset. A partner who communicates with the same empathy-first, solution-forward approach you are building internally will extend your culture to every patient they touch.
- ***Early-out first-party program capability.*** If a prospective partner does not offer this, keep looking.
- ***Transparency and reporting.*** You should be able to see exactly what is happening to your accounts at any point.
- ***Licensing and compliance.*** In California, any agency collecting on behalf of another entity must hold a current DFPI license under the Debt Collection Licensing Act. Verify this before signing anything.

Once you have the right partner, place accounts early and consistently. Do not wait until you have a large batch. Establish a weekly or bi-weekly placement schedule so accounts move promptly when your internal cadence is complete. Brief your partner on your service area, payer mix, and patient population. Review results together monthly or quarterly. The agencies that get the best results treat their partners as collaborators, not vendors.

Patient Engagement as a Continuous Strategy

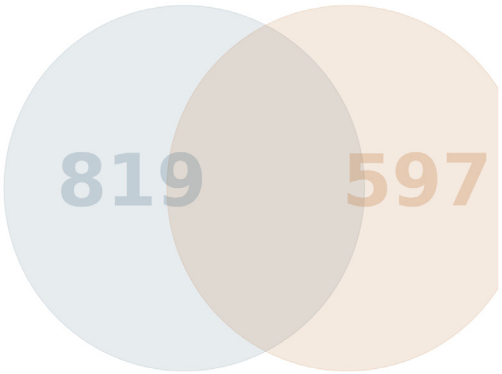
Patient engagement is not a phase of the revenue cycle. It is a continuous strategy that begins the moment a transport happens and does not end until every reasonable avenue for resolution has been pursued. Internal ownership and training create the foundation. A structured contact cadence keeps accounts from aging invisibly. The right outside partner extends your reach when internal capacity runs out.

California ambulance providers are operating in one of the most challenging financial environments in the history of EMS. But the revenue that is available, the accounts that are genuinely collectible if someone engages with them thoughtfully and promptly, is there to be recovered.

Your patients deserve a billing experience that reflects the quality of care they received. And your company deserves to be paid for the work it does. A thoughtful patient engagement strategy, built from the inside out and supported by the right outside partners, makes both of those things possible.

Same Data,
Different Truths

The Case for Data
Governance in EMS



By Mario Vargas, MSc, CPHQ, EMT-P

Same Data, Different Truths:

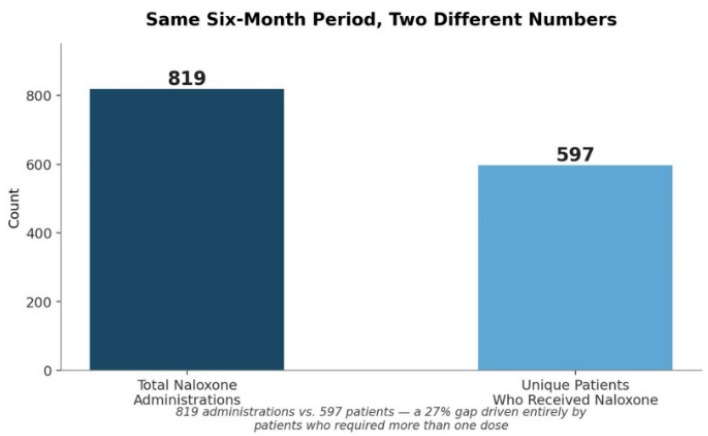
The Case for Data Governance in EMS

Mario Vargas, MSc, CPHQ, EMT-P

A few months ago, our medical director and I sat down to review naloxone administrations across the county. We were looking at the same six-month window, from the same source system, and found we'd arrived at two different numbers.

One version counted total naloxone administrations. The other counted unique patients who received naloxone. Over that period, our system recorded 819 administrations, but only 597 individual patients. Neither number was wrong, we'd simply never agreed on which question "naloxone administrations" was supposed to answer.

That gap isn't trivial. It's driven almost entirely by patients who needed more than one dose, 172 of them, or 29% of everyone treated, required repeat dosing on scene. Whether you use 819 or 597 as your baseline changes how you size a buprenorphine induction program, how you staff an opioid response unit, and how you interpret whether overdose severity is rising or falling in your community. Both numbers are accurate. Only one of them answers the question you're actually trying to ask, and until someone points that out, most organizations never find out which one they've been using.



819 administrations vs. 597 patients — a 27% gap driven entirely by patients who required more than one dose

How This Actually Happens

This kind of gap isn't a data quality failure. It's a governance failure, and it's built into how most EMS organizations produce data in the first place.

A leader is handed a mandate, "fix this trend", "show improvement", "find out why a number moved", and

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hands it off to an analyst to pull. The analyst chooses the filters, the date range, the inclusion criteria, and the definition of the metric, usually without documented guidance, because none exists. The output comes back and drives a conclusion: "we need to fix this", "we're doing great", "look how much we improved", "look how much we slipped". The methodology behind that conclusion is rarely questioned, unless the number is the wrong kind of surprising.

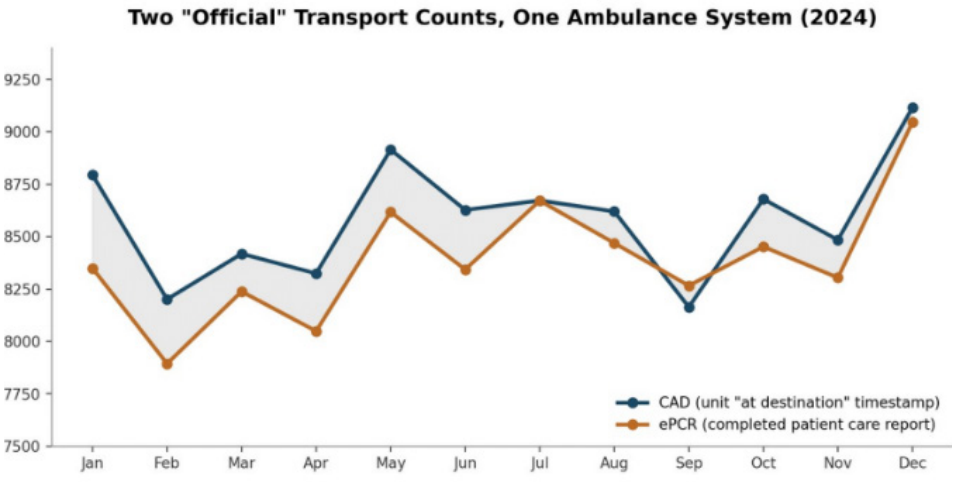
That last part is the real problem. In most organizations, data only gets scrutinized retroactively, and only when it disappoints someone. A number that confirms what leadership already believes sails through. A number that contradicts it gets picked apart. That isn't measurement, it's motivated auditing, and it means the same undefined methodology can be treated as gospel one quarter and as suspect the next, depending on nothing more than whether people liked the answer.

A Second Example: How Many Transports Did We Actually Run?

The naloxone gap isn't an isolated case. Pull "total transports" for our system in 2024 from two different, both entirely legitimate sources, and you get two different answers.

The CAD system counts a transport the moment a unit logs an "at destination" timestamp. The ePCR platform counts a transport when a completed patient care report documents one. For 2024, CAD recorded 103,013 transports. Completed ePCRs recorded 100,697, a gap of 2,316, or about 2.3% annually.

That gap isn't constant. It ran as high as 5.1% in January and as low as 0.8% in December, and in September, it briefly reversed, with ePCR-documented transports outnumbering CAD timestamps. Anyone reconciling billing against operations, or setting a unit-hour utilization target against a transport volume forecast, is choosing, knowingly or not, which of these two numbers is "real."



Annual totals: 103,013 (CAD) vs. 100,697 (ePCR) — a 2,316-transport, 2.3% gap that moves month to month and briefly reverses direction in September

A Third Example: Which System, Which Statistic?

The first two examples are about what gets counted. This one is about which system you trust and how you summarize what it tells you, and it may be the governance question organizations are least willing to admit they have.

Same fleet, same month, four defensible numbers. The CAD system tracks a call from scene arrival through call closure, the whole event, scene time and transport and hospital wait bundled together. Restricted to calls that resulted in a transport, that interval averaged 81 minutes, 16 seconds across roughly 8,700 records in March, with a 90th percentile of 107 minutes, 1 second. The ePCR platform's ambulance patient offload time (APOT) report isolates a narrower window, hospital arrival to transfer-of-care time, averaging 21 minutes, 30 seconds across about 8,800 records that same month, with a 90th percentile of 44 minutes, 4 seconds.

Every one of those four numbers is legitimate. They're measuring genuinely different things. But that's exactly the risk: cite CAD's 90th percentile and the system looks like it's in crisis. Cite ESO's average from the same month and it looks well under control. Nothing about either number is wrong, what's missing is a documented, shared understanding of which system, which window, and which statistic represents "performance," and who has the authority to decide.

This is the part of governance nobody wants to admit out loud: people don't reach for a different system or a different statistic by accident. Whoever is making an argument tends to reach for whichever

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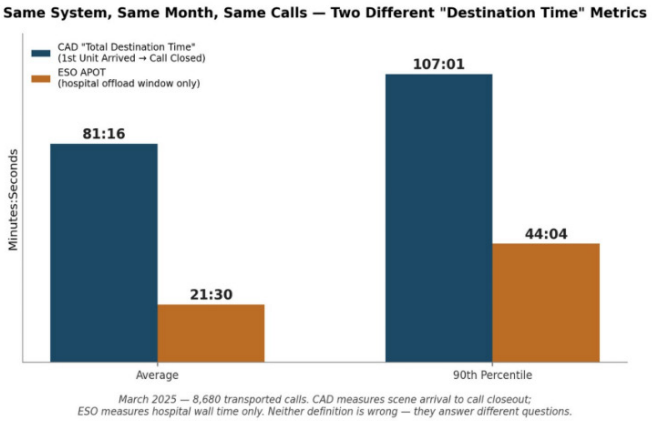
combination happens to support the conclusion they already hold, the widest window and the highest percentile to prove a crisis, the narrowest window and the average to prove things are fine. Governance isn't only about picking one number. It's about deciding, in advance and out loud, which system, which window, and which statistic the organization stands behind, so the same argument can't be re-litigated with a different spreadsheet every time the answer is inconvenient.



What Data Governance Actually Means

Data governance sounds like something only large health systems need committees for. That framing undersells it. At its core, governance is simply the set of documented decisions about how data is defined, scoped, collected, summarized, and used, and who has the authority to make those decisions, made before the pull, not argued about after.

A simple test: if two analysts pulled the same metric, from the same system, over the same window, would they get the same number, calculated the same way? If the answer depends on who's asking, what they hope to find, or which system and statistic they happen to reach for, you don't have governance. You have institutional habit, and institutional habit walks out the door every time someone leaves.

EMS is especially exposed to this problem. Our data lives across CAD, ePCR, hospital outcome feeds, and billing platforms that were never designed to talk to each other. Add data entered under pressure, at scene, by providers focused on patient care rather than documentation precision, and you have a system where "the number" is rarely as simple as it looks on a dashboard.

What Changes When You Name It

None of the three gaps above required anyone to be wrong. Once the actual difference got named, whether administrations versus patients, one clock versus another, or an average versus a percentile, the conversation stopped being about whose number to trust and started being about which question the number was supposed to answer. In each case, the fix looked the same: document both figures, agree on which one governs going forward, and stop treating either total as self-evident.

That shift is worth more than any single metric fix. A defined term turns a disagreement between colleagues who respect each other into a five-minute conversation instead of a credibility fight.

The Takeaway

If your organization can't say, in a sentence, how "transport," "destination time," or "administration" is defined, what interval it spans, which statistic represents it, and who has the authority to change any of that, you don't have a data problem waiting to happen. You have one already, quietly running in the background of every report you've ever presented to your medical director, your board, or your county EMS agency.

The fix isn't a new dashboard or a bigger analytics team. It's deciding, before the next disagreement, what you're actually counting, over what window, and how you're summarizing it, and writing it down so the next person doesn't have to guess.

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I agree to place a _____ size ad in the following issue(s), and to be billed at a rate of $_____ per issue: (note: The multiple-issue rate can apply to *any* consecutive series of issues starting at any point in the year. If you choose the multi-issue rate, please number your first issue "#1" below, and the other issues as they occur chronologically. See condition #5, above.)

	_____Fall	_____Winter	_____Spring	_____Summer
Material Deadlines:	**July 24, 2026**	**November 13, 2026**	**January 22, 2026**	**April 16, 2027**

METHOD OF PAYMENT

Total $_____ **Please check one:**
☐ Send me an Invoice ☐ Enclosed is check #_____ (Payable to CAA) ☐ Charge my Credit Card ○ MC ○ Visa ○ AmEx
Last 4 digits of card: _____ Billing Address: _____
Print Cardholder's Name: _____ Signature: _____

(rev. 5/26)

Full Credit Card# _____ Exp: _____ CVV#: _____

Return completed form and payment by mail or fax to: **California Ambulance Association, 1502 W Broadway Suite 102 • Monona, WI 53713 • (916) 924-7323 – fax**
For more information, contact us at: (916) 239-4095 – phone • (877) 276-1410 – toll free • *www.the-caa.org*

CALIFORNIA AMBULANCE ASSOCIATION
1502 W BROADWAY, SUITE 102
MONONA, WI 53713 • www.the-caa.org
877.276.1410 (toll free) • 916.924.7323 (fax)

Congratulations to the 2026 CAA Stars of Life!