DUTCHESS COUNTY

EMERGENCY MEDICAL SERVICES TASK FORCE

FINAL REPORT
March 2017
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EXECUTIVE SUMMARY

In his 2016 State of the County Address, Dutchess County Executive Marcus Molinaro announced the forming of an Emergency Medical Services Task Force to study the current state of, and to provide recommendations for improvement in, the delivery of Emergency Medical Services (EMS). He charged the Task Force specifically to identify, develop, and recommend county coordinated solutions for an EMS system with the attributes of being Patient Centered, Consistent, Reliable, Affordable, and Sustainable.

At the core of various challenges facing EMS that the ensuing Task Force report reviews, is the lack of a legal mandate that the provision of emergency medical care is an essential service, as are fire protection and law enforcement. Since its inception in the 1960s, EMS has evolved into an expected public service. The entity taking responsibility varies from jurisdiction to jurisdiction. Fire Districts direct most EMS activity in Dutchess County. However, in some areas, the local municipal government manages contractual relationships with commercial EMS providers. The New York Department of Health regulates an agency’s certificate of need, authorizes patient care protocols, and certifies ambulances and EMS providers.

A multitude of providers, volunteer fire departments, career fire departments, volunteer ambulance corps, and commercial EMS agencies deliver EMS in Dutchess County. They vary in level of care from Basic Life Support Services (BLS) to Advanced Life Support Services (ALS). Some fire districts have contracts with commercial providers to provide ALS Services to assist their BLS Services, or use them as their primary response agency.

When experiencing an emergency, the level of care a patient receives in the county depends upon several factors, including their location, time of day, and day of the week. Some agencies utilize ALS crews on weekdays from 9am to 5pm, or roster their BLS crews only in the evenings and on weekends, or are unable to provide more than one ambulance at a time. A person therefore could receive very different care if calling for help at 4pm versus 6pm, or on weekends or evenings, or if they are the second or third person calling for help at the same time.

EMS in the county is severely strained, as demonstrated by lengthening response times and reduced levels of care, and in some cases, has failed the community as local services no longer exist or cannot respond, even if they appear on paper that they can. In early-2016, Dutchess County lost a commercial ALS ambulance provider, and a mere few months later lost a volunteer BLS fire department ambulance. In early 2017, a municipal fire department ALS transport ambulance service has changed to an ALS first response service only, and utilizes a commercial ALS provider for their transport needs.

The EMS Task Force report describes the complex challenges that have created the current state of pre-hospital care in the county, which is inefficient, inconsistent, non-standardized, fragmented and not patient centered. The same problem exists from state to state throughout the nation. At the federal level, EMS is not a mandated service, there exists no national authority, there is a lack of dedicated funding, and a lack of insurance reimbursement regulation. At the state level, the laws of ‘home-rule’ impede collaboration and shared-services, there exists insufficient funding and reimbursement, and a lack of standardized systems design. At the local level, there is inadequate operational coordination and
decision making, no standard acceptable level of service county-wide, poor public knowledge and perception, significant decrease in volunteer providers, and poor surge capability.

As detailed throughout this report, Dutchess County Government does not have specific jurisdictional authority to directly address all of the aforementioned issues and provide this important service. However, mechanisms and potential statutory options do exist to allow for this service to be provided from a county perspective which would require local agency and/or municipality relinquishment of authority. At this time, the EMS Task Force does not recommend this option.

The EMS Task Force has made several recommendations included in the report, the final being the consideration of an Emergency Service Authority. If the community agrees the establishment of an authority is the desired solution, the EMS Task Force recommends contracting with a consultant to develop the strategy and the implementation plan for creating the Emergency Service Authority. The consultant may identify challenges to overcome such as legal requirements and barriers, institute tactics for gaining political and emergency services community support, define authority powers and organizational structure.
ACKNOWLEDGEMENTS

Many thanks to the following people for their participation and contributions to the EMS Task Force from sectors such as Emergency Medical Services, Fire Services, and Public Health; county and local government; strategic planning within Dutchess County; county, town and village legal issues; finance and administration; and the historical context and significance of a variety of organizations as they relate to critical public services. Those members marked with an asterisk are on the EMS Task Force steering committee:

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Bruce Cutler, (Red Hook)

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*Anthony Ruggiero, City Manager, City of Beacon
Mark Johnson, Fire Chief, City of Poughkeepsie
Dave Shultz, Town of North East

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*Tim Murphy, Union Vale Fire District; President, Dutchess County EMS Council

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Bernadette Cekuta, Program Coordinator, Dutchess Community College Emergency Services

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Dewitt Sagendorph, Commissioner, Staatsburg Fire District
*Chris Maeder, Chief, Fairview Fire District
Dan Nichols, Chief, Roosevelt Fire District

Continued next page
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Jerry Landisi

New York State Department of Health Bureau of Emergency Medical Services
Richard Robinson, Regional EMS Program Administrator
Kevin Gage, Senior Emergency Medical Care Representative

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Senator Sue Serino (represented by Anil Beephan)
Assembly Member Didi Barrett (represented by Bill Gustafson)
Assembly Member Kevin Cahill
Assembly Member Frank Skartados

Subject Matter Expert Presenters
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Special Recognition
Bill Yellin, Dutchess County Office of Central and Information Services
Susan Sellitto, Dutchess County Department of Emergency Response
Laurie Colgan, Dutchess County Department of Emergency Response
Dr. David Gavin, Assistant Professor, School of Management, Marist College

Special Note
Marist College provided unwavering and exceptional support to the work and mission of the EMS Task Force and Steering Committee. The college, Dr. David Gavin and students from the School of Management spent countless hours analyzing millions of data points from the Dutchess County Office of Central and Information Services to create manageable and meaningful information, tables and infographics. Additionally, Dr. Gavin provided support as an advisor, guide, and mentor to the Task Force and Steering Committee. The Marist community demonstrated the integrity of their values in action: excellence in education, a sense of community, and a commitment to service.
**GLOSSARY OF ACRONYMS**

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
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<td>ACR</td>
<td>Ambulance Call Report</td>
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<td>AED</td>
<td>Automated External Defibrillator</td>
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<td>AEMT</td>
<td>Advanced Emergency Medical Technician</td>
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<tr>
<td>AEMT-P</td>
<td>Advanced Emergency Medical Technician - Paramedic</td>
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<td>AHA</td>
<td>American Heart Association</td>
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<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
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<td>AMA</td>
<td>Against Medical Advice</td>
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<td>AMI</td>
<td>Acute Myocardial Infarction</td>
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<td>AMS</td>
<td>Altered mental status</td>
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<tr>
<td>AVL</td>
<td>Auto Vehicle Locator</td>
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<td>BCLS</td>
<td>Basic Cardiac Life Support</td>
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<td>BEMS</td>
<td>Bureau of Emergency Medical Services</td>
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<td>BLS</td>
<td>Basic Life Support</td>
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<td>BNE</td>
<td>Bureau of Narcotics and Exchange</td>
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<td>BSI</td>
<td>Body Substance Isolation</td>
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<td>CAD</td>
<td>Computer Aided Dispatch</td>
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<td>Critical Care Unit</td>
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<td>CDC</td>
<td>Centers for Disease Control</td>
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<td>CE</td>
<td>County Executive</td>
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<td>CFR</td>
<td>Certified First Responder</td>
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<td>CIC</td>
<td>Certified Instructor Coordinator</td>
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<td>CLI</td>
<td>Certified Lab Instructor</td>
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<td>CME</td>
<td>Continuing Medical Education</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CON</td>
<td>Certificate of Need</td>
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<td>CPR</td>
<td>Cardio-Pulmonary-Resuscitation</td>
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<td>CVA</td>
<td>Cerebro-Vascular Accident</td>
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<td>DCC</td>
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<td>Dutchess County Department of Emergency Response</td>
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<td>DCMAC</td>
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<td>DNR</td>
<td>Do Not Resuscitate</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DOT</td>
<td>US Department of Transportation</td>
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<td>DSRIP</td>
<td>Delivery System Reform Incentive Payment Program (NYS)</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>EAP</td>
<td>Employee Assistance Program</td>
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<td>ECG (EKG)</td>
<td>Electro-Cardio-Gram</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EMD</td>
<td>Emergency Medical Dispatch</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>EMT</td>
<td>Emergency Medical Technician</td>
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<td>EOC</td>
<td>Emergency Operations Center</td>
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<tr>
<td>ePCR</td>
<td>Electronic Pre-Hospital Care Report</td>
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<td>ER</td>
<td>Emergency Room</td>
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<tr>
<td>ETA</td>
<td>Estimated Time of Arrival</td>
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<td>FCC</td>
<td>US Federal Communications Commission</td>
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<td>FD</td>
<td>Fire Department</td>
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<td>FEMA</td>
<td>Federal Emergency Management Agency</td>
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<td>FR</td>
<td>First Response (Agency)</td>
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<td>HAZMAT</td>
<td>Hazardous Materials</td>
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<td>HVREMAG</td>
<td>Hudson Valley Regional Medical Advisory Committee</td>
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<td>HVREMSCO</td>
<td>Hudson Valley Regional Emergency Medical Services Council</td>
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<tr>
<td>IAFC</td>
<td>International Association of Fire Chiefs</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>ITR</td>
<td>Inability to Respond</td>
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<td>IOM</td>
<td>Institute of Medicine</td>
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<td>IV</td>
<td>Intravenous</td>
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<tr>
<td>LOSAP</td>
<td>Length of Service Award Programs</td>
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<td>MC</td>
<td>Medical Control</td>
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<td>MCI</td>
<td>Multiple (Mass) Casualty Incident</td>
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<tr>
<td>MD</td>
<td>Medical Doctor</td>
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<td>MHRH</td>
<td>Mid-Hudson Regional Hospital of Westchester Medical Center</td>
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<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>MLSS</td>
<td>Mobile Life Support Services, Inc.</td>
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<tr>
<td>MOI</td>
<td>Mechanism of Injury</td>
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<tr>
<td>MOU/MOA</td>
<td>Memorandum of Understanding/Agreement</td>
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<tr>
<td>Muni-CON</td>
<td>Municipal Certificate of Need</td>
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<tr>
<td>MVA(C)</td>
<td>Motor Vehicle Accident (Collision)</td>
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<tr>
<td>NAEMSE</td>
<td>National Association of EMS Educators</td>
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<td>NDP</td>
<td>Northern Dutchess Paramedics</td>
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<td>NEMSIS</td>
<td>National Emergency Medical Services Information Systems</td>
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<td>NFPA</td>
<td>National Fire Protection Association</td>
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<td>NHTSA</td>
<td>National Highway Traffic Safety Administration</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>NREMT</td>
<td>National Registry of Emergency Medical Technicians</td>
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<td>NYS</td>
<td>New York State</td>
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<td>OB</td>
<td>Obstetrics</td>
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<td>OD</td>
<td>Overdose</td>
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<td>OEM</td>
<td>Office of Emergency Management</td>
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<tr>
<td>OFPC</td>
<td>Office of Fire Prevention and Control</td>
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<tr>
<td>PA</td>
<td>Physician’s Assistant</td>
</tr>
<tr>
<td>PAD</td>
<td>Public Access Defibrillation</td>
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<tr>
<td>PALS</td>
<td>Pediatric Advanced Life Support</td>
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<tr>
<td>PCR</td>
<td>Patient Care Report</td>
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<tr>
<td>PD</td>
<td>Police Department</td>
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<tr>
<td>PHTLS</td>
<td>Pre-Hospital Trauma Life Support</td>
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<td>PIO</td>
<td>Public Information Officer</td>
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<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>QA / QI</td>
<td>Quality Assurance / Improvement</td>
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<td>REMAC</td>
<td>Regional Medical Advisory Committee</td>
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<tr>
<td>REMSCO</td>
<td>Regional Emergency Medical Services Council</td>
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<tr>
<td>RHIO</td>
<td>Regional Health Information Organization</td>
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<tr>
<td>RMA</td>
<td>Refused Medical Assistance</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RSI</td>
<td>Rapid Sequence Intubation</td>
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<tr>
<td>SCT</td>
<td>Specialty Care Transport</td>
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<td>SEMAC</td>
<td>State Emergency Medical Advisory Committee</td>
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<tr>
<td>SEMSCO</td>
<td>State Emergency Medical Services Council</td>
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<tr>
<td>SSM</td>
<td>System Status Management</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strength Weakness Opportunity Threat</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
</tr>
<tr>
<td>TOA</td>
<td>Transfer of Authority</td>
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<tr>
<td>TQM</td>
<td>Total Quality Management</td>
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<tr>
<td>VBMC</td>
<td>Vassar Brothers Medical Center</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WMD</td>
<td>Weapons of Mass Destruction</td>
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EVOLUTION OF EMS

The current essential mission of Emergency Medical Services (EMS) is to treat and transport the ill and injured in the peri-hospital environment. EMS Systems (EMSS) are the complex sum of interconnected components working together to provide communities with emergent and comprehensive healthcare, given available operational, financial, legal, and political resources. EMS is a relatively new profession: the pre-hospital and post-hospital treatment and transport components only received recognition within the last 50 years; and ‘community paramedicine’ is a new model of integrated care utilizing facets of primary, social service, elder, specialized, and alternative care, treatment and transport fulfilling the vision from the 1990s that the profession would be community-based health management fully integrated with the overall health care system. While EMS may fall under a variety of jurisdictions including public safety, public health, and others, the vision was that it would be an integrated agency among them.

Just as communities vary greatly, so do their healthcare systems. EMS agencies in such systems may be different in organization and structure, and may provide more or less service based on their aforementioned resources. Historically, volunteers made up local EMS services, typically housed within fire departments, and organizations supplied a varying mix of either or both to their communities. Organizations provided essential services and also served as cultural and social centers, funded largely through donations. At the time, as is largely the practice today, local government recognized volunteer fire departments and first-aid squads as organizations providing such services to their municipalities. Today, however, a broader mix is more prevalent among organizational types (private, municipal, or non-profit), make up (career and/or volunteer), level of service, and funding (private pay or ability to bill for service, tax-based, or contract). Additionally, each combination of organizational type, make-up, level of service, and funding ability may have a slightly different mission / vision while purporting to fall under the umbrella of ‘public safety’, ‘public health’, or other similar designation.

For many reasons (a reduction in volunteerism; increased operating costs, training requirements, regulation, and/or demand for services) many of the current EMS organizations within the county operate inefficiently (high cost to service ratio), are not effective (provide inconsistent service that is dependent upon staffing and equipment – which varies among agencies) and do not provide equal coverage of services across the entire county. Some agencies, because of a lack of support from volunteers, have closed completely leaving entire populations without essential services. As such, throughout New York State there are many small, ineffective, inefficient, expensive agencies delivering EMS care.

In Dutchess County, 64 separate volunteer fire stations and 47 separate volunteer EMS stations exist. Each station is different in ability to respond, personnel coverage and availability, training, equipment, apparatus and services. All certified personnel and agencies, however, must meet a variety

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of minimum national and state standards and regulations to maintain operational status, regardless of efficiency or effectiveness. Responsibility for providing Fire and EMS services in New York State resides in local political subdivisions (county, city, town, or village). General municipal law requires cities and villages to provide fire protection, and allows towns and counties to provide fire protection directly or indirectly through contracted services or by recognition of service by a city or village.

Regarding EMS, New York State General Municipal Law indicates political subdivisions of county, town, city or village may provide prehospital emergency medical services but does not implicitly indicate a municipality must or shall. New York State Public Health Law grants the ability for an agency to provide EMS service by providing an operating certificate and regulates such services through Article 30, regardless of the type of service (municipal, private, not-for-profit) or level of service (First Response only – CFR, Basic Life Support – BLS, or Advanced Life Support – ALS). As such, an EMS agency may possess an operating certificate that covers a range of political subdivisions while a fire service may only operate, aside from mutual aid agreement, in a local political subdivision such as a village or city, or special district as subdivided by a town or county. To that end, New York State Constitution Article IX ‘Municipal Home Rule Law’ gives local municipalities the power to enact local law, which can lead to a dramatic variance of service across larger political subdivisions. These are complex issues wherein fragmentation is fostered and there exist few subject matter experts at local levels to advocate for integration into a larger and more comprehensive system of care.

**EMS DATA ANALYSIS**

The Task Force found it necessary to determine the trend of certain data, as some of the objective tools in assessing the ability of an agency to meet the charge as set forth by the County Executive for a “County coordinated solutions for an EMS system must demonstrate the attributes of being Patient Centered, Consistent, Reliable, Affordable, and Sustainable.” To meet these guiding principles, the Task Force analyzed trends of data related to emergency requests; demographic data including population density and geographic location; distance and travel time in miles and minutes to area hospitals; inability to respond (ITR) and subsequent use of another agency’s resources; and use of other services.

The Task Force utilized data from the Dutchess County Department of Emergency Response (DCDER) to ensure a reliable and standardized set of information for statistical analysis. The data were analyzed with Marist College in conjunction with Dutchess County Office of Central and Information Services. It was analyzed using Microsoft Excel and IBM SPSS Statistics 24 software. The components of the data sets listed in the Town-By-Town tables in the addendum reflect the following information:

**At Scene:** This is the time it takes an agency to arrive at a scene. It is calculated from the time of dispatch to the time the agency calls ‘on-scene’. Some agencies may demonstrate lower response times because the agency ‘rosters’ crews at the station, because crews are already in

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ambulances and ready to respond, or because the alarms are closer to the locations where agencies staff ambulances or are physically located.

_In Service:_ This is the time it takes an agency to call ‘back in service’ after the completion of an alarm. Alarm times for this data vary for a variety of reasons. Some agencies do not call ‘back in service’ until the crew returns to the border of their jurisdiction; in such a case their average in-service time may seem longer comparatively. Some agencies, especially commercial agencies, will call ‘back in service’ as soon as they arrive at the hospital; in such a case their average in-service time may seem shorter comparatively. Other factors include but are not limited to: the distance to a hospital (the further from a hospital the longer the in-service time), weather, traffic, road conditions, time of day, geography, patient condition, hospital acuity/capacity, and others.

_Inability to Respond:_ This data presents the times that DCDER dispatches an agency and the agency does not respond to the alarm. Reasons vary but include the inability to staff ambulances, or crews are already on other alarms. In such a case, resources from other agencies must handle the alarm.

_It should be noted, at no time did our data indicate a call went unanswered. If an agency could not respond another agency had to respond to the scene._

The Task Force compiled the data in the tables so that the reader could see a five-year trend of alarm time averages by year, and alarm volume by year. An additional column in the alarm time table presents a total average alarm time, while the addition column in the alarm volume table represents the total volume of alarms over the five-year timeframe.

The agency listed at the bottom of the sheet represents the ‘home’ agency in the town and other tables on the sheet represent mutual-aid agencies that responded to an alarm in the ‘home’ agency area. Such agencies could have responded because of a failure of the primary/home agency to crew, to manage multiple patients at a single incident alongside the primary agency, or to provide an additional level of care to a patient as requested by the primary agency (ex: advanced life support). The tables reflect the data of those mutual-aid agencies involved in responses out of their primary response area, into a neighboring agency’s area, and do not reflect data for such agencies within their own response areas.
EMS TASK FORCE DESCRIPTIVE FINDINGS

Nationally
- EMS is not a mandated public service under federal law.
- There is no single federal agency guiding EMS.
- Multiple federal agencies set varying standards (Department of Transportation, Health and Human Services).
- There is no significant or dedicated funding similar to fire, law enforcement and emergency management.
- There are no national standards or benchmarks for the delivery of EMS; there are national standards to obtain and maintain provider certification/licensure.
- There is little to no knowledge across federal agencies regarding EMS.
- The national populace has little knowledge regarding EMS.
- As a result there is little acknowledgement of professional value to society and minimal influence for policy making, as in fire and law enforcement services.
- There is poor, inconsistent, and declining reimbursement from insurance companies.
- The Affordable Care Act may continue to negatively impact reimbursement.

New York State
- EMS is not a mandated public service under state law.
- EMS is housed in NYS Department of Health (NYS DOH), which has less than optimal funding and staff dedicated to EMS programs.
- NYS DOH promulgates patient protocols, baseline administrative and equipment requirements, and provider education. This does not sufficiently address the 5 attributes as outlined by County Executive Marcus Molinaro.
- NYS DOH does not have a centralized training arm similar to NYS Office of Fire Prevention and Control.
- NY is a Home Rule State, local agencies and municipalities set most of the service standards. This creates wide variations in service delivery between jurisdictions.
- Quality and consistency benchmarks are inconsistent across service boundaries.
- There is little to no oversight on quality or consistency of service delivery.
- There is little to no agreement on standardization/benchmarks for service delivery.
- The community-at-large has a lack of knowledge about EMS (i.e. “Ambulance Drivers”).
- As a result there, is little acknowledgement of professional value to society and minimal influence for policy making, as in fire and law enforcement services.
- There are no consistent or dedicated funding or grant opportunities for EMS as compared to fire, law enforcement and emergency management.
- There is poor, inconsistent, and declining reimbursement from insurance companies.
- The Affordable Care Act may continue to negatively impact reimbursement.

County and Locally
- EMS is not a mandated public service under any local law.
- Since the local entities individually address (Home Rule) EMS there is not a systems approach which impacts delivery and quality of EMS.
Many local officials lack the experience and knowledge regarding EMS to make corporate or operational decisions.

Most local decisions and solutions are developed without collaboration of local partners.

Lack of acceptable standards for delivery of EMS.

Inconsistent levels of service and response between jurisdictions.

No centralized body to set standards and oversee delivery/operations, service is fragmented and inconsistent.

Significant variation in agreements, in formality and standards, between fire districts and municipalities with commercial agencies (from verbal, handshake, to written contracts with variances in deliverables).

These variations can and do result in inadequate coverage in some areas.

Areas that have formal agreements, set response standards, dedicated units, responsibility and accountability processes in place, subsequently, have proven to have more reliable and consistent EMS coverage from commercial agencies.

Based on the descriptive findings noted here and numerous societal changes, the previous model of strictly volunteer only service is extremely challenged at best. In some cases, the challenges are so significant; the service is no longer operational.

The challenges and societal changes are likely to continue

Every BLS Volunteer agency in the County has some type of prearranged response coverage.

Automatic or prearranged aid should not be considered mutual aid

Geography and demographics significantly impact the delivery of service and the quality/operations (i.e. rural vs. suburban)

Delivery of EMS is traditionally fire based in Dutchess County, which creates unique challenges.

The delivery of EMS has been supplemented by commercial services.

Fire Districts are prohibited by NYS law from billing for services.

County citizens have little knowledge regarding EMS.

As a result there is little professional value to society and minimal influence for policy making.

Varied sources, inconsistent, no dedicated funding.

Poor or no reimbursement from insurance companies; impact of ACA.

Limited understanding of usefulness of advances in information technology tools and lack of funding to implement new technologies.

Limited to no healthcare system collaboration.

Limited and inconsistent information on patient outcomes.

No capacity for increase in volume or multi casualty event (surge).

Fragmented and decentralized training for providers.

No systemic approach to Quality Assurance/Quality Improvement.

Future

The predicted increase in the aging population will increase EMS call volume.

Data shows a 17% increase over the last 6 years (2011-2016)

Projected change in geographical population density across the County.

Continued decrease numbers of available volunteers county-wide.

Decrease in EMS certified provider recruitment pool.

EMS and emergency healthcare delivery changes (i.e. ACA, DSRIP, NYS regulations).
CONCLUSIONS

The EMS Task Force has developed the following conclusions concerning the provision of emergency medical care in Dutchess County. The conclusions drawn were guided by the 5 principles set forth by the County Executive: that an EMS system should be patient centered, reliable, consistent, affordable and sustainable.

Patient Centered

Many of the Task Force descriptive findings identified impact EMS operations specifically, with less impact on patient care. The NYS Basic Life Support and collaborative Advanced Life Support (ALS) protocols along with certification training and continuing education allow dedicated providers to provide excellent patient care. Evaluating patient care outcomes is disjointed due to the decentralized and fragmented nature of the current EMS system.

Regulatory Deficiencies

At the national, state and local level there are a variety of comparable circumstances that impact the delivery and effectiveness of EMS. The major influencer for the fragmentation and decentralization of the current EMS system is the lack of a federal agency responsible for EMS and that it is not a mandated public safety service. Other significant influencers include no dedicated funding, no agreed upon standard of response capability, level or quality of care, and no adopted benchmarks to evaluate delivery. All of these factors result in EMS having to be addressed at the local level. Current standards address baseline treatment protocols, administrative regulations and minimal equipment requirements at the state level. Moreover, there is little acknowledgement of the professional value to society and minimal influence for policy making, as in fire and law enforcement services.

Fragmented Delivery

There has been little to no collaboration between agencies or municipalities on EMS delivery leading to fragmented operations conducted at the local level. Decisions are based on the immediate individual community or agency need. There has been very minimal consideration for addressing the provision of emergency medical care from a regional or a multi-jurisdictional systems approach. Since there are no agreed upon standards and no central authority to enforce standards, the ensuing service often lacks effectiveness, especially involving the 5 guiding principles.

Diminishing Volunteer Capacity

Traditionally, EMS in Dutchess County has been provided by local fire department based volunteers. Over the last 20 years volunteer based services have seen a decline in the number of volunteers coupled with an increasing call volume. This trend has resulted in volunteer based services being supplemented by either career staff hired through the home agency or through formal and informal agreements with commercial ambulance services. Most volunteer agencies have experienced an increased reliance on commercial services to meet daily demand and in some departments the hiring of career staff has occurred. Each volunteer-based agency in the County has some form of prescheduled coverage every day.

Challenges for Career and Commercial Agencies

In the departments where volunteer resources have been replaced or supplemented by career staff, the ability to increase staffing has a significant impact on budgets and on the tax burden for the local taxpayer.

Commercial ambulances services operational costs continue to rise, while reimbursement from insurance carriers has not increased at the same pace. In fact, some insurance companies have actually decreased reimbursement rates and reimbursement is negatively impacted by the Affordable Care Act.
The decreasing reimbursement has contributed to two commercial agencies ceasing operations in Dutchess County in recent years. Out of necessity, commercial agencies today require a financial subsidy from most municipalities or agencies they provide service to. The agencies and municipalities that are not providing a financial subsidy, for the most part, have no guarantee of response.

No Standards on Coverage

Within Dutchess County, there are various arrangements for supplemental EMS response between municipalities, fire departments and commercial EMS agencies.

The following are the types of variances that exist:

- **No formal agreement or contract with a supporting agency:** Agencies or municipalities that have no formal agreement in place are faced with response inconsistencies. At any given time, it is not known if a unit is available to respond. While commercial agencies make reasonable efforts to be available, there is no contractual mandate they do so. The void created by lack of committed resources has a direct negative impact on neighboring communities. Resources are pulled from another jurisdiction and must travel a greater distance to get to the patient. Thus, increasing the void in response capabilities.

- **A formal written agreement with no subsidy for a supporting agency:** Agencies or municipalities that have an agreement but no subsidy generally have an improved supporting response. However, without a subsidy there is no financial support or compensation for the agency to keep units available to respond.

- **A Less than 24 hour coverage agreement and subsidy with a supporting agency:** Agencies or municipalities that have an agreement with non-24 hour coverage with subsidy have a predictable response during the contract hours. For the most part, at least one unit is dedicated to that community. The challenge is a consistent response from either agency during the non-contracted hours. There are inconsistencies for the home agency and the supplemental agency in providing predictable and consistent service. The timeliness of the response and the level of care vary greatly based on the day of the week and time of the day.

- **24 hour coverage agreement and subsidy with a provider:** Agencies or municipalities with 24 hour coverage whether through career staff or via contract with a commercial agency with subsidy, have consistent and reliable service for the routine EMS call volume in their community.

The Descriptive Findings and Conclusions noted in this Task Force report demonstrate that the current provision of emergency medical care is minimally patient centered, unreliable, inconsistent, fiscally costly and unsustainable. Moreover, the lack of a comprehensive systems approach produces inequitable levels of care and response to County residents. All of these attributes jeopardizes public safety and the overall well-being of our community.
THE VISION

In order for movement towards an EMS system we must first define the vision of a system that is Patient Centered, Consistent, Reliable, Affordable and Sustainable.

Patient Centered is the concept that the process for making decisions places the patient at the very core, not just in clinical care but in operational tactics as well. The focus is on the individual patient's needs and concerns not what may be the most convenient, fastest or least expensive for the provider or agency.

The requisite need for Consistent, Reliable, Affordable and Sustainable are self-evident as the descriptive findings describe an absence of these attributes. Essentially, the EMS system should have quality assurance, dependability to respond 24/7/365 with equitable level of care across the county and expenditures are strategically anticipated, accounted for and monitored.

The system exists for the patient, these attributes are not independent tenets, and they are intimately intertwined as in interlocking circles and should function as such.

OPTIONS AND RECOMMENDED SOLUTIONS

Current State of the System

Today the provision of EMS is fragmented, and the lack of effective coordination and accountability stand in the way of further progress and improved quality of care. In its current state, the EMS infrastructure will continue to degrade and the attributes of being patient centered, consistent, reliable, affordable, and sustainable will not be attainable. All stakeholders in the EMS system have an opportunity to move toward a more integrated and accountable system through fundamental systemic changes. The Task Force developed immediate, short-term, and long-term recommendations as identified below:

Immediate: Coordination of EMS Provider Education and Training

The Task Force recognized an immediate solution to a concurrent strength, weakness, and opportunity identified by the SWOT analysis as related to education. Many reputable organizations, course sponsors, and institutions provide necessary and quality education throughout the county, typically at low or no cost. However, providers have no centralized or standardized venue to access information about the availability of such education. As such, and through the work of Task Force members, Dutchess County EMS and Regional EMS committees, the Hudson Valley Regional EMS Council (HVREMSCO) approved the purchase and implementation of a new region-wide calendar system available to all providers and educators. The system will allow educators to post their training programs, and give providers access to find any training throughout the Region. This solution is currently being implemented across the six-county area of the Hudson Valley Region.
Immediate: Conduct Public Forums as well as Emergency Service Forums

There has been displayed interest on this subject expressed by members of the general public. Providing an opportunity to gather the input of the public, the user of the service, and to present the findings and recommendations of the taskforce is paramount. We are recommending a series of public forums spread throughout Dutchess County.

We are also recommending a separate series of presentations with the Fire and EMS community to discuss the findings and review the recommendations. The greater Fire and EMS community needs to be engaged and support the process of establishing a centralized EMS system.

Intermediate: Political and Public Safety Education

EMS is highly regulated, has many complex nuances, and can be quite expensive to operate in order to provide quality service in a community. Too often, local leaders are forced by finances, limited knowledge, crisis, or urgent need to make quick and sometimes uninformed decisions. Local leaders may not have the ability to develop or implement a strategic long-term plan. Recent history demonstrates that circumstances force such personnel to identify the most convenient resource available at the least expensive cost, or completely cease operations which may negatively impact residents within the jurisdiction. Regulations and laws regarding EMS do not address, and there is limited impetus to find a solutions that are, patient centered, consistent, reliable, affordable and sustainable.

The current EMS infrastructure experiences significant changes to operations, educational requirements, and clinical care. Moreover, leaders in the EMS change regularly because individuals advance their careers by moving onto other professions or to other organizations and the voting public or agency membership (i.e. FD) elect new leaders.

As such, there exists a tremendous lack of legitimate guidance for such leaders. The Task Force recommends that the county develop a comprehensive standardized EMS leadership educational program inclusive of, but not limited to, the following, and available for all persons involved in the delivery, decision-making, guidance, and responsibility of providing EMS:

- History and development of EMS
- The governing structure for EMS
- Pertinent laws and regulations, including the CON and municipal CON process
- Major concepts in delivery of high quality EMS
- Service delivery models
- Funding models
- Challenges facing the clinical and operational delivery of EMS
- Collaboration/shared service and regionalization
- RFP and contract development
Intermediate: Citizens Advisory Committee

The Emergency Medical Services (EMS) Task Force is recommending the establishment of a Citizens Advisory Committee for EMS. The mission of the committee would be to collaborate work with local municipalities, providers, and the community at large to develop and implement solutions for EMS that are patient centered, reliable, consistent, affordable and sustainable.

The objectives for the Citizens Advisory Committee include:

- Identify community and provider expectations for the delivery of EMS
  - do they expect an ambulance with trained personnel; what level of training (BLS, ALS)
  - importance or value on the quality on the care provided
  - Identify local communities ability/desire to establish and maintain an effective EMS response that is equitable
- Provide education and guidance for local leaders on current laws, regulations, mission of EMS
- Identify models for the improvement of the provision of EMS that may be feasible within Dutchess County
  - Inclusive of regulatory considerations
  - Identify shared services opportunities
- Provide recommendations to local and county leaders to the most appropriate method/model for EMS provision in Dutchess County
  - consideration of an Emergency Services Authority

Long Term: Consideration of an Emergency Services Authority

In order to address the myriad of issues within the county’s current delivery of EMS, a potential solution is the creation of an Emergency Services Authority. The objective of the authority would be to provide a coordinated solution for the delivery of EMS among its members, which could include individual agencies, and local municipalities, that is *Patient Centered, Consistent, Reliable, Affordable, and Sustainable*. Such an authority would allow those organizations involved in the delivery of EMS to continue their service to their community, and become an interdependent and symbiotic partner with the authority as well. It could be created, as an autonomous governmental agency, under an act of New York and Dutchess County Legislatures.

A countywide Emergency Services authority with a Board of Directors, Governance Board, Executive Officer, and employees, guided by a mission statement, would be able to set the direction for participating agencies to provide quality EMS\(^8\). Additionally, the authority will have the ability to create a vision of excellence in the delivery of emergency services, ability to be progressive and agile to meet the evolving needs of stakeholders in Dutchess County.

Adequate funding will drive the ability to provide EMS and potentially other essential services. Ultimately, the authority would need to be designed to receive and generate (billing) revenue and distribute resources based on regulations, procedures and policies as determined by the authorities By-laws. Municipalities and agencies agreeing to participate in the authority would be required to meet minimum standards as outlined by the authority.

The process of creating the authority will start by providing education and information to stakeholders on the benefits of creating an authority to provide a better and more sustainable service. The support of our local and state level elected officials so that effective legislation can be enacted, is imperative. Goals for engaging and informing elected officials include creating a proposed charter that will identify the mission, how the authority will receive funding, the services the authority will provide, and the makeup of the Board of Directors and/or Governance Board.

The Taskforce recommends contracting with a consultant to develop the strategy and the implementation plan for creating the Emergency Service Authority. The consultant may identify challenges to overcome such as legal requirements and barriers, institute tactics for gaining political and emergency services community support, define authority powers and organizational structure.
APPENDICIES

Agreements or contracts in place for EMS by agency/municipality

**No contract in place:**
- East Clinton
- Milan
- Pine Plains
- Stanford
- Tivoli
- Red Hook
- Rhinebeck
- West Clinton

**Contract but no subsidy:**
- Beacon
- City of Poughkeepsie
- Roosevelt
- Fairview
- Arlington Fire

**Partial Coverage-Contract and subsidy in place:**
- East Fishkill
- Pleasant Valley
- Union Vale
- Millbrook/Town of Washington

**Contract with Subsidy-24/7 coverage**
- Amenia (01/01/2017)
- Beekman
- Dover
- Fishkill-Town
- Fishkill-Village
- Hyde Park (Staatsburgh and Hyde Park Districts)
- LaGrange- career fire
- North East
- Pawling
- T/Poughkeepsie- New Hamburg Fire District
- Wappinger-Town
- Wappinger-Village
**SWOT Analysis**

<table>
<thead>
<tr>
<th>SWOT</th>
<th>Comment on Current Strategy</th>
<th>Gap or No Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>Numerous and frequent educational sessions. Sufficient instructors/lecturers Sufficient sponsors/hosts Sufficient labs/classroom space</td>
<td>Central coordination group Accessible training calendar Include specialize businesses (Laerdal)</td>
</tr>
<tr>
<td>Radio System/911 Dispatch</td>
<td>Centralized 911 CAD – data and uniformity EMD</td>
<td>Share CAD data with EMS community – collate and make accessible. Standardized report per each agency New queries for specific data to drive decisions New technologies. Is 911 up to date and prepared for future?</td>
</tr>
<tr>
<td>EMS Providers</td>
<td>Dedicated; collaborative; experienced; professional</td>
<td>Public recognition of value and knowledge of providers Engage providers throughout county Conduct survey as to what motivates them and retains their services</td>
</tr>
<tr>
<td>Hospitals</td>
<td>EMS liaisons; Medical Control</td>
<td>Bring hospital decision makers into discussions to identify ways they enhance &amp; support EMS (i.e. support career path through scholarships, internships)</td>
</tr>
<tr>
<td>Equipment</td>
<td>Sufficient; meet regulations, MCI trailers</td>
<td>Adequately distributed throughout county? Standardized throughout county (ePCRs)?</td>
</tr>
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## MITIGATING WEAKNESSES

<table>
<thead>
<tr>
<th>SWOT</th>
<th>Comment on Current Strategy</th>
<th>Gap or No Gap</th>
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</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>Insufficient number of providers, especially in volunteer sector; Lack of 24/7 coverage for entire county; pockets of areas with poor availability.</td>
<td>Educate county residents and politicians on major EMS challenges. Set minimum standard for entire county (i.e. 24/7 BLS transport for every resident with ALS intercept). Then develop plan to meet the standard.</td>
</tr>
<tr>
<td>Coverage</td>
<td>See above - combined</td>
<td></td>
</tr>
<tr>
<td>Financial: Cost</td>
<td>Tax base funding – costs increasing Some volunteer agencies operate on donations only FD unable to bill insurance (this alone will not solve funding issues)</td>
<td>Legislative changes – educate community, politicians, and policy makers (NYS DOH) Link volunteer agencies that rely on donations to FD tax base? Regionalization/consolidation evaluated for efficacy</td>
</tr>
<tr>
<td>Revenue Recovery</td>
<td></td>
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<tr>
<td>Interagency Relations (willingness to merge)</td>
<td>Agencies/departments unwilling to share resources for the greater good.</td>
<td>Share data to highlight issues/problem. Clearly identify issues and project future outcomes if not solved (potential impact to community and integrity/reputation of the agency).</td>
</tr>
<tr>
<td>SWOT</td>
<td>Comment on Current Strategy</td>
<td>Gap or No Gap</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>-------------------------------------------------------------------------------</td>
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<tr>
<td>Political Influence</td>
<td>Community and politicians are beginning to become engaged</td>
<td>Increase outreach to Community &amp; politicians. Invite to Task Force forums.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop White paper and Task Force report.</td>
</tr>
<tr>
<td>Technology</td>
<td>ePCR; data analysis; websites; social media</td>
<td>Assist all agencies to obtain ePCR capability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop/use current technology to collate data</td>
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<tr>
<td></td>
<td></td>
<td>Leverage technology in the provision of patient care</td>
</tr>
<tr>
<td>Redesign EMS System: Community Paramedicine Regionalization /Shared Services</td>
<td></td>
<td>Enhance career options that support residents needs and work alongside current healthcare professions (i.e. home care; discharge planners, public health)</td>
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<tr>
<td></td>
<td></td>
<td>Use current and predictive data to identify weaknesses, set a minimum standard for the community; and to support regionalization/consolidation/shared services</td>
</tr>
<tr>
<td>Public Relations and Education on EMS</td>
<td></td>
<td>Increase PR to highlight the value of EMS, providers, and Community needs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educate politicians and residents on EMS.</td>
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<tr>
<td></td>
<td></td>
<td>Engage private businesses to help (Laedral, colleges, healthcare facilities) – have a fund to support a PR person?</td>
</tr>
<tr>
<td>SWOT</td>
<td>Comment on Current Strategy</td>
<td>Gap or No Gap</td>
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<td>------</td>
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</tr>
<tr>
<td><strong>Availability</strong> &lt;br&gt; Recruitment / Retention</td>
<td>Time constraints &lt;br&gt; Training requirements &lt;br&gt; Requirements to maintain “active” status &lt;br&gt; Work-family life balance &lt;br&gt; Other commitments (volunteer for other organizations) &lt;br&gt; If career – multiple jobs to make living wage.</td>
<td>Look to agencies with adequate volunteers for the community &amp; membership demographics for their service area; why are they doing ok? County-wide recruitment efforts...unified approach to highlight benefits and requirements. Ensure all volunteers have minimum “benefits” (LOSAP, insurance coverage or low cost group coverage).</td>
</tr>
<tr>
<td><strong>Aging Population</strong> &lt;br&gt; Increased Call Volume &lt;br&gt; Healthcare Trends</td>
<td>Census projections for next 10-20 years? May not have pool of people to volunteer (aging population). May have to go to all paid staff EMS system. Healthcare trends...aging in place and effects on community resources (healthcare, public health and social services) – Community Paramedicine. Collaborate with homecare agencies and public health.</td>
<td></td>
</tr>
<tr>
<td><strong>Finance:</strong> &lt;br&gt; Funding Sources &lt;br&gt; Revenue Recovery &lt;br&gt; Taxes</td>
<td>Mid to long term goal would be legislative changes to support EMS...FD billing, Federal/State funding stream, county wide –multi-agency collaborative grant applications</td>
<td></td>
</tr>
<tr>
<td><strong>Value of EMS:</strong> &lt;br&gt; Status/Worth</td>
<td>Increase PR and political influence to ensure EMS providers at same level (status and access to support service/funds) to FD/PD.</td>
<td></td>
</tr>
</tbody>
</table>
Recommended Reading

Previous Dutchess County reports:
  Changing Times in the Fire Service; 2003
  Paving the Way to the Future Symposium; 2006

Other NYS County EMS reports:
  Greene County
  Madison County

National publications:
  Innovations in EMS:
    http://dot.sinaiem.org/
  Emergency Medical Services: Decreasing Revenue and the Regulated Healthcare Environment:
  National EMS Assessment:
  EMS Agenda for the Future:
  Accidental Death and Disability:
Town by Town Infographics and Agency Alarm Data

The following pages present the data gathered by the Task Force, compiled and summarized as explained in the EMS System Data and Analysis section above. The Task Force arranged the following pages alphabetically by township and then by agency within the township. Any abbreviations within the following pages correlate as follows:

14024 City of Poughkeepsie
AMFD Amenia
ARFD Arlington
BEFD Beekman
BNFD City of Beacon
CHFD Chelsea
CPFD Castle Point
DEC NYS DEC Property
DJFD Dutchess Junction
DOFD Dover
ECFD East Clinton
EFFD East Fishkill
FAFD Fairview
FIFD Fishkill
GLFD Glenham
HIFD Hillside
HPFD Hyde Park
HUFD Hughsonville
LAFD Lagrange
MBFD Millbrook
MIFD Milan
MNFD Millerton
NHFD New Hamburg
NKFD New Hackensack
PAFD Pawling
PPFD Pine Plains
PVFD Pleasant Valley
RCFD Rhinecliff
RHFD Red Hook
RMFD Rombout
ROFD Roosevelt
SBFD Staatsburg
STFD Stanford
TIFD Tivoli
UVFD Unionvale
WAFD Wappinger
WCFD West Clinton
WPFD Wappingers

The committee provided notes within each of the following pages, to assist the reader in understanding the complex and diverse nuances among the various townships and agencies and how they address the provision and delivery of emergency medical care.

Infographic Key of Symbols:

- Hospital
- EMS Basic Life Support Agency (Squad or Corp)
- EMS Basic Life Support Agency (Fire Department Based)
- EMS Advanced Life Support Agency (Commercial)
- EMS Advanced Life Support Agency (Fire Department Based)
Town by Town Infographics
### Town by Town Infographics and Agency Alarm Data

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**Infographic Key of Symbols:**
- HOSPITAL
- EMS Basic Life Support Agency (Squad or Corp)
- EMS Basic Life Support Agency (Fire Department Based)
- EMS Advanced Life Support Agency (Commercial)
- EMS Advanced Life Support Agency (Fire Department Based)
**Castle Point**

**Transcare**

- **Transcare calls per year**

  - 2011: 100
  - 2012: 120
  - 2013: 140
  - 2014: 160
  - 2015: 180

**Mobile Life**

- **Mobile Life calls per year**

  - 2011: 20
  - 2012: 40
  - 2013: 60
  - 2014: 80
  - 2015: 100

---

**Population**

- 5,522

**Square Miles**

- 1.2

**Population Density (0-7500)**

- 4,983

**EMS Providers**

<table>
<thead>
<tr>
<th>Mobile Life</th>
<th>Commercial</th>
<th>ALS AMB</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS EMS</td>
<td>BLS FIRE</td>
<td>ALS Commercial</td>
</tr>
<tr>
<td></td>
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<td>ALS Municipal</td>
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</tbody>
</table>

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**Map**

- NORTHERN DUTCHESS: 25 Miles, 37 Minutes
- SHARON: 38 Miles, 56 Minutes
- MHRH VBMC: 8 Miles, 13 Minutes
- ST LUKES: 11 Miles, 18 Minutes
- PUTNAM: 30 Miles, 39 Minutes
City of Beacon

Beacon Ambulance

Beacon Ambulance calls per year

Mobile Life

Mobile Life calls per year

Transcare

Transcare calls per year

AVERAGE AT SCENE TIME  AVERAGE IN SERVICE TIME

AT SCENE  IN SERVICE  INABILITY TO RESPOND

Population
Square Miles
Population Density (0-7500)

EMS Providers

Beacon Ambulance  Career +Volunteer  BLS AMB
Beacon FD  Career  No TXP
Mobile Life  Commercial  ALS AMB
City of Poughkeepsie

Pending data coordination with the City of Poughkeepsie.
Town of Amenia (1 of 2)  *Amenia*

**Population**  4,436

**Square Miles**  43.6

**Population Density (0-7500)**  103

<table>
<thead>
<tr>
<th>EMS Providers</th>
<th>Type</th>
<th>Code</th>
</tr>
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<tbody>
<tr>
<td>Amenia FD</td>
<td>Volunteer</td>
<td>BLS AMB</td>
</tr>
<tr>
<td>Wassaic FD</td>
<td>Volunteer</td>
<td>BLS AMB (until Aug. 2016)</td>
</tr>
<tr>
<td>NDP</td>
<td>Commercial</td>
<td>ALS AMB</td>
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</tbody>
</table>
### Town of Amenia (2 of 2)  
**Wassaic**

#### EMS Providers

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>ALS/Commercial</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Amenia FD</td>
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<td>ALS AMB</td>
<td></td>
</tr>
</tbody>
</table>

#### Population and Area Statistics

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
</tr>
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<tbody>
<tr>
<td>Population</td>
<td>4,436</td>
</tr>
<tr>
<td>Square Miles</td>
<td>43.6</td>
</tr>
<tr>
<td>Population Density</td>
<td>103</td>
</tr>
</tbody>
</table>

#### Average Response Times

- **Wassaic FD**:  
  - Average AT Scene Time: [Graph]  
  - Average In Service Time: [Graph]

- **NDP**:  
  - Average AT Scene Time: [Graph]  
  - Average In Service Time: [Graph]  
  - Average Inability to Respond: [Graph]

#### Call Counts

<table>
<thead>
<tr>
<th>Year</th>
<th>Wassaic FD Calls</th>
<th>NDP Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
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<tr>
<td>2013</td>
<td></td>
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<tr>
<td>2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Town of Clinton (1 of 2) East Clinton

**East Clinton FD**

- 2011: 28 minutes
- 2012: 28 minutes
- 2013: 28 minutes
- 2014: 28 minutes
- 2015: 28 minutes

**Transcare**

- 2011: 36 minutes
- 2012: 36 minutes
- 2013: 36 minutes
- 2014: 36 minutes
- 2015: 36 minutes

**NDP**

- 2011: 43 minutes
- 2012: 36 minutes
- 2013: 28 minutes
- 2014: 28 minutes
- 2015: 28 minutes

**East Clinton FD calls per year**

- 2011: 100 calls
- 2012: 150 calls
- 2013: 200 calls
- 2014: 150 calls
- 2015: 100 calls

**Transcare calls per year**

- 2011: 100 calls
- 2012: 150 calls
- 2013: 200 calls
- 2014: 150 calls
- 2015: 100 calls

**NDP calls per year**

- 2011: 250 calls
- 2012: 200 calls
- 2013: 150 calls
- 2014: 100 calls
- 2015: 50 calls

**EMS Providers**

- East Clinton FD: Volunteer, BLS AMB
- West Clinton FD: Volunteer, BLS AMB
- NDP: Commercial, ALS AMB

**Population**

- 4,312

**Square Miles**

- 38.8

**Population Density (0-7500)**

- 113
Town of Clinton (2 of 2) West Clinton

**Population**
4,312

**Square Miles**
38.8

**Population Density (0-7500)**
113

**EMS Providers**
- East Clinton FD: Volunteer, BLS AMB
- West Clinton FD: Volunteer, BLS AMB
- NDP: Commercial, ALS AMB

**Graphs**
- West Clinton FD and West Clinton FD calls per year
- NDP and NDP calls per year

**Charts**
- Average at scene time and in service time for West Clinton FD and NDP
- Average at scene time, in service time, and inability to respond for West Clinton FD and NDP calls per year
Town of Dover

Population: 8,699
Square Miles: 56.3
Population Density (0-7500): 158

EMS Providers:
- Dover FD: Volunteer, BLS AMB
- NDP: Commercial, BLS +ALS AMB
Town of East Fishkill

Population 29,029

Square Miles 57.4

Population Density (0-7500) 514

EMS Providers

- East Fishkill FD
  - Volunteer
  - BLS AMB
- Mobile Life
  - Commercial
  - ALS AMB

AVERAGE AT SCENE TIME
AVERAGE IN SERVICE TIME
AT SCENE IN SERVICE INABILITY TO RESPOND

East Fishkill FD

Mobile Life

East Fishkill FD calls per year

Mobile Life calls per year

NORTHERN DUTCHESS
37 Miles 43 Minutes

MHRH VBMC
15 Miles 29 Minutes

ST LUKES
16 Miles 21 Minutes

PUTNAM
19 Miles 25 Minutes

BLS EMS
BLS FIRE
ALS Commercial
ALS Municipal

2011 2012 2013 2014 2015

00:00 00:14 00:28 00:43 00:57 01:12 01:26

0:00 0:05 0:10 0:15 0:20 0:25 0:30

0 500 1000 1500
Town of Fishkill (1 of 5) Village of Fishkill

Population: 22,107
Square Miles: 32.0
Population Density (0-7500): 809

EMS Providers:
- Beacon Ambulance: Career + Volunteer
- Glenham FD: Volunteer
- Mobile Life: Commercial
- Dutchess Junction FD: Volunteer
- Chelsea FD: Volunteer

Graphs showing Mobile Life calls per year.
**Town of Fishkill (2 of 5) Glenham**

### Population and Area Details
- **Population**: 22,107
- **Square Miles**: 32.0
- **Population Density (0-7500)**: 809

### EMS Providers

<table>
<thead>
<tr>
<th>EMS Provider</th>
<th>Type</th>
<th>Location</th>
<th>Distance</th>
<th>Average AT Scene Time</th>
<th>Average In Service Time</th>
<th>AT Scene</th>
<th>In Service</th>
<th>Inability to Respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Ambulance</td>
<td>Career + Volunteer</td>
<td>BLS Ambulance</td>
<td>49 Minutes</td>
<td>0:00:00</td>
<td>0:05:7</td>
<td>0:00:28</td>
<td>0:00:00</td>
<td>0:00:00</td>
</tr>
<tr>
<td>Transcare</td>
<td>Volunteer</td>
<td>BLS Ambulance</td>
<td>25 Minutes</td>
<td>0:00:00</td>
<td>0:04:3</td>
<td>0:00:21</td>
<td>0:00:00</td>
<td>0:00:00</td>
</tr>
<tr>
<td>Mobile Life</td>
<td>Commercial</td>
<td>ALS Ambulance</td>
<td>29 Minutes</td>
<td>0:00:00</td>
<td>0:05:7</td>
<td>0:00:28</td>
<td>0:00:00</td>
<td>0:00:00</td>
</tr>
</tbody>
</table>

### Transcare Calls per Year
- **2011**: 0
- **2012**: 300
- **2013**: 300
- **2014**: 300
- **2015**: 300

### Mobile Life Calls per Year
- **2011**: 0
- **2012**: 20
- **2013**: 40
- **2014**: 60
- **2015**: 80

### Graphs
- **Beacon Ambulance**
- **Beacon Ambulance calls per year**
- **Transcare**
- **Transcare calls per year**
- **Mobile Life**
- **Mobile Life calls per year**
**Town of Fishkill (3 of 5) Dutchess Junction**

**Beacon Ambulance**
- Population: 22,107
- Square Miles: 32.0
- Population Density (0-7500): 809

**EMS Providers**
- **Beacon Ambulance**: Career + Volunteer
- **Glenham FD**: Volunteer
- **Mobile Life Support**: Commercial
- **Dutchess Junction FD**: Volunteer
- **Chelsea FD**: Volunteer

**Beacon Ambulance calls per year**
- 2011: 0
- 2012: 0
- 2013: 0
- 2014: 0
- 2015: 0

**Transcare**
- Population: 22,107
- Square Miles: 32.0
- Population Density (0-7500): 809

**Transcare calls per year**
- 2011: 0
- 2012: 0
- 2013: 0
- 2014: 0
- 2015: 0
Town of Fishkill (4 of 5)  Rombout

Population  22,107
Square Miles  32.0
Population Density (0-7500)  809

EMS Providers
- Beacon Ambulance  Career + Volunteer  BLS AMB
- Glenham FD  Volunteer  No TXP
- Mobile Life  Commercial  ALS AMB
- Dutchess Junction FD  Volunteer  No TXP
- Chelsea FD  Volunteer  No TXP

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT SCENE</td>
<td>0</td>
<td>500</td>
<td>1000</td>
<td>1500</td>
<td>2000</td>
</tr>
<tr>
<td>IN SERVICE</td>
<td>0</td>
<td>500</td>
<td>1000</td>
<td>1500</td>
<td>2000</td>
</tr>
<tr>
<td>INABILITY TO RESPOND</td>
<td>0</td>
<td>500</td>
<td>1000</td>
<td>1500</td>
<td>2000</td>
</tr>
</tbody>
</table>

Mobile Life calls per year
- 2011  2200
- 2012  2300
- 2013  2400
- 2014  2500
- 2015  2600

Map showing locations and distances:
- NORTHERN DUTCHESS 29 Miles 49 Minutes
- SHARON 39 Miles 59 Minutes
- MHRH VBMC 12 Miles 25 Minutes
- ST LUKES 8 Miles 13 Minutes
- PUTNAM 24 Miles 29 Minutes
Town of Fishkill (5 of 5) Chelsea

**Population**

<table>
<thead>
<tr>
<th></th>
<th>27,048</th>
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</table>

**Square Miles**

<table>
<thead>
<tr>
<th></th>
<th>28.5</th>
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</table>

**Population Density (0-7500)**

<table>
<thead>
<tr>
<th></th>
<th>1,000</th>
</tr>
</thead>
</table>

**Emergency Services**

- **Beacon Ambulance**
  - Career + Volunteer
  - BLS AMB

- **Glenham FD**
  - Volunteer
  - No TXP

- **Mobile Life**
  - Commercial
  - ALS AMB

- **Dutchess Junction FD**
  - Volunteer
  - No TXP

- **Chelsea FD**
  - Volunteer
  - No TXP
Town of Hyde Park (1 of 2) *Hyde Park/Staatsburg*

### Hyde Park/NDP

**Hyde Park/NDP calls per year**

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls</td>
<td>1500</td>
<td>1000</td>
<td>500</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**AVERAGE AT SCENE TIME**

- 2011: 0:21
- 2012: 0:14
- 2013: 0:07
- 2014: 0:00
- 2015: 0:00

**AVERAGE IN SERVICE TIME**

- 2011: 0:14
- 2012: 0:07
- 2013: 0:00
- 2014: 0:00
- 2015: 0:00

### Staatsburg / NDP

**Staatsburg / NDP calls per year**

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls</td>
<td>800</td>
<td>600</td>
<td>400</td>
<td>200</td>
<td>0</td>
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</tbody>
</table>

**AVERAGE AT SCENE TIME**

- 2011: 0:28
- 2012: 0:14
- 2013: 0:14
- 2014: 0:00
- 2015: 0:00

**AVERAGE IN SERVICE TIME**

- 2011: 0:14
- 2012: 0:07
- 2013: 0:00
- 2014: 0:00
- 2015: 0:00

### Population and EMS Providers

- **Population**: 21,571
- **Square Miles**: 39.8
- **Population Density (0-7500)**: 588

### EMS Providers

- **NDP**
  - Commercial
  - ALS AMB
- **Staatsburg FD**
  - Volunteer
  - No TXP
- **Roosevelt FD**
  - Volunteer
  - BLS AMB
- **Mobile Life**
  - Commercial
  - ALS AMB
- **Pleasant Valley FD**
  - Volunteer
  - BLS AMB
- **Pleasant Valley FD**
  - Career
  - No TXP
- **Fairview FD**
  - Career+ Volunteer
  - BLS AMB
- **Hyde Park FD**
  - Volunteer
  - No TXP
Population: 21,571
Square Miles: 39.8
Population Density (0-7500): 588

**Roosevelt FD**
- Calls per year
- Mobile Life calls per year

**Roosevelt / Mobile Life**
- Calls per year

**Mobile Life**
- Calls per year

### EMS Providers

<table>
<thead>
<tr>
<th>Population</th>
<th>21,571</th>
</tr>
</thead>
<tbody>
<tr>
<td>Square Miles</td>
<td>39.8</td>
</tr>
<tr>
<td>Population Density (0-7500)</td>
<td>588</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMS Providers</th>
<th>NDP</th>
<th>Staatsburg FD</th>
<th>Roosevelt FD</th>
<th>Mobile Life</th>
<th>Pleasant Valley FD</th>
<th>Fairview FD</th>
<th>Hyde Park FD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Commercial</td>
<td>Volunteer</td>
<td>Commercial</td>
<td>Volunteer</td>
<td>Career</td>
<td>Career + Volunteer</td>
<td>Volunteer</td>
</tr>
<tr>
<td>Service</td>
<td>ALS AMB</td>
<td>No TXP</td>
<td>ALS AMB</td>
<td>BLS AMB</td>
<td>No TXP</td>
<td>BLS AMB</td>
<td>No TXP</td>
</tr>
</tbody>
</table>
Town of LaGrange

Population: 15,730
Square Miles: 40.3
Population Density (0-7500): 394

EMS Providers

<table>
<thead>
<tr>
<th>LaGrange FD</th>
<th>Career</th>
<th>ALS AMB</th>
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</thead>
<tbody>
<tr>
<td>Lagrange FD</td>
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<tr>
<td>Lagrange FD calls per year</td>
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<td></td>
</tr>
<tr>
<td>Arlington FD</td>
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<td></td>
</tr>
<tr>
<td>Arlington FD calls per year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Bar charts depict average at scene time and average in service time for Lagrange and Arlington fire departments over the years 2011 to 2015.
Population: 2,370
Square Miles: 36.6
Population Density (0-7500): 74

EMS Providers:
- Milan FD: Volunteer BLS AMB
- NDP: Commercial ALS AMB
Town of Northeast

**Population** | 3,031
---|---
**Square Miles** | 43.7
**Population Density (0-7500)** | 74

**EMS Providers**
- **Millerton FD**: Volunteer, BLS AMB
- **NDP**: Commercial, ALS AMB
Town of Pine Plains

Population | 2,473
Square Miles | 31.2
Population Density (0-7500) | 81

<table>
<thead>
<tr>
<th>EMS Providers</th>
<th>Pine Plains FD</th>
<th>Volunteer</th>
<th>BLS AMB</th>
<th>NDP</th>
<th>Commercial</th>
<th>ALS AMB</th>
</tr>
</thead>
</table>

AVERAGE AT SCENE TIME
AVERAGE IN SERVICE TIME
AT SCENE
IN SERVICE
INABILITY TO RESPOND

NORTHERN DUTCHESS
17 Miles
23 Minutes

SHARON
15 Miles
21 Minutes

MHRH VBMC
29 Miles
42 Minutes

ST LUKES
50 Miles
56 Minutes

PUTNAM
53 Miles
60 Minutes

BLS EMS
BLS FIRE
ALS Commercial
ALS Municipal
Town of Pleasant Valley

**Population** | 9,672
---|---
**Square Miles** | 33.1
**Population Density (0-7500)** | 297

**EMS Providers**

- **Pleasant Valley FD**
  - Volunteer
  - BLS AMB
- **Pleasant Valley FD**
  - Career
  - No TXP
- **Mobile Life**
  - Commercial
  - ALS AMB
Town of Poughkeepsie (1 of 3) Arlington

Arlington FD

Arlington FD calls per year

Mobile Life

Mobile Life calls per year

EMS Providers

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>ALS</th>
<th>BLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arlington FD</td>
<td>Career + Volunteer</td>
<td>No TXP</td>
<td></td>
</tr>
<tr>
<td>Fairview FD</td>
<td>Career + Volunteer</td>
<td>BLS AMB</td>
<td></td>
</tr>
<tr>
<td>Mobile Life</td>
<td>Commercial</td>
<td>ALS AMB</td>
<td></td>
</tr>
<tr>
<td>New Hamburg FD</td>
<td>Volunteer</td>
<td>No TXP</td>
<td></td>
</tr>
</tbody>
</table>

Population: 43,341
Square Miles: 31.2
Population Density (0-7500): 1,520
Town of Poughkeepsie (2 of 3) Fairview

**Population**
43,341

**Square Miles**
31.2

**Population Density (0-7500)**
1,520

**EMS Providers**
- Arlington FD: Career + Volunteer, ALS No TXP
- Fairview FD: Career + Volunteer, BLS AMB
- Mobile Life: Commercial, ALS AMB
- New Hamburg FD: Volunteer, No TXP
Town of Poughkeepsie (3 of 3) **New Hamburg**

**Population:** 43,341

**Square Miles:** 31.2

**Population Density (0-7500):** 1,520

**EMS Providers**

- **Arlington FD**: Career + Volunteer, ALS No TXP
- **Fairview FD**: Career + Volunteer, BLS AMB
- **Mobile Life**: Commercial, ALS AMB
- **New Hamburg FD**: Volunteer, No TXP
Town of Red Hook (1 of 2) Red Hook

Red Hook FD

Population

Square Miles

Population Density (0-7500)

EMS Providers

<table>
<thead>
<tr>
<th>Red Hook FD</th>
<th>Volunteer</th>
<th>BLS AMB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tivoli FD</td>
<td>Volunteer</td>
<td>BLS AMB</td>
</tr>
<tr>
<td>NDP</td>
<td>Commercial</td>
<td>ALS AMB</td>
</tr>
</tbody>
</table>
Town of Red Hook (2 of 2) Tivoli

**Population**
11,319

**Square Miles**
40.0

**Population Density (0-7500)**
313

**EMS Providers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Hook FD</td>
<td>Volunteer</td>
<td>BLS AMB</td>
</tr>
<tr>
<td>Tivoli FD</td>
<td>Volunteer</td>
<td>BLS AMB</td>
</tr>
<tr>
<td>NDP</td>
<td>Commercial</td>
<td>ALS AMB</td>
</tr>
</tbody>
</table>
### Population
- **Population**: 7,548
- **Square Miles**: 39.7
- **Population Density (0-7500)**: 212

### EMS Providers
- **Rhinebeck FD**: Volunteer, BLS AMB
- **Rhinecliff FD**: Volunteer, BLS AMB
- **NDP**: Commercial, ALS AMB
Town of Rhinebeck (2 of 2) Rhinecliff

Population | 7,548
Square Miles | 39.7
Population Density (0-7500) | 212

EMS Providers
- Rhinebeck FD: Volunteer, BLS AMB
- Rhinecliff FD: Volunteer, BLS AMB
- NDP: Commercial, ALS AMB

Rhinecliff FD
- Rhinecliff FD calls per year
- Average at scene time: 2011 - 0:00, 2012 - 0:07, 2013 - 0:14, 2014 - 0:21, 2015 - 0:28
- Average in service time: 2011 - 0:00, 2012 - 0:07, 2013 - 0:14, 2014 - 0:21, 2015 - 0:28

NDP
- NDP calls per year
- Average at scene time: 2011 - 0:00, 2012 - 0:07, 2013 - 0:14, 2014 - 0:21, 2015 - 0:28
- Average in service time: 2011 - 0:00, 2012 - 0:07, 2013 - 0:14, 2014 - 0:21, 2015 - 0:28
Town of Union Vale

### Population
- **4,877**

### Square Miles
- **37.8**

### Population Density (0-7500)
- **130**

### EMS Providers
<table>
<thead>
<tr>
<th>Union Vale FD</th>
<th>Volunteer</th>
<th>BLS AMB</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMSTAR</td>
<td>Commercial</td>
<td>ALS AMB</td>
</tr>
</tbody>
</table>

![Graphs showing Union Vale FD and Transcare call volumes and average response times from 2011 to 2015.](image-url)
Town of Wappinger (2 of 3) Hughsonville

Population: 27,048
Square Miles: 28.5
Population Density (0-7500): 1,000

EMS Providers:
- Hughsonville FD: Volunteer, No TXP
- Chelsea FD: Volunteer, No TXP
- EMSTAR: Commercial, ALS AMB

Graphs show Wappinger calls per year from 2011 to 2015, with bars indicating average at scene time, average in service time, at scene, in service, and inability to respond.
Town of Wappinger (3of 3) New Hackensack

### Wappinger

<table>
<thead>
<tr>
<th>Year</th>
<th>AVERAGE AT SCENE TIME</th>
<th>AVERAGE IN SERVICE TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Wappinger calls per year

<table>
<thead>
<tr>
<th>Year</th>
<th>AT SCENE</th>
<th>IN SERVICE</th>
<th>INABILITY TO RESPOND</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
<td></td>
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<td>2013</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EMS Providers

- **Hughsonville FD**: Volunteer, No TXP
- **Chelsea FD**: Volunteer, No TXP
- **EMSTAR**: Commercial, ALS AMB
Town of Washington

<table>
<thead>
<tr>
<th>Population</th>
<th>4,741</th>
</tr>
</thead>
<tbody>
<tr>
<td>Square Miles</td>
<td>58.9</td>
</tr>
<tr>
<td>Population Density (0-7500)</td>
<td>82</td>
</tr>
</tbody>
</table>

**EMS Providers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>ALS/AMB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Millbrook FD</td>
<td>Volunteer</td>
<td>BLS AMB</td>
</tr>
<tr>
<td>NDP</td>
<td>Commercial</td>
<td>ALS AMB</td>
</tr>
<tr>
<td>East Clinton FD</td>
<td>Volunteer</td>
<td>BLS AMB</td>
</tr>
</tbody>
</table>
Village of Wappingers Falls

**Population**

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls</td>
<td>0</td>
<td>500</td>
<td>1000</td>
<td>1500</td>
<td>2000</td>
</tr>
</tbody>
</table>

**EMS Providers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Commercial</th>
<th>ALS AMB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile Life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Average AT Scene Time**

- 2011: 0:00:00
- 2012: 0:01:26
- 2013: 0:02:53
- 2014: 0:04:19
- 2015: 0:05:46

**Average In Service Time**

- 2011: 0:00:00
- 2012: 0:01:26
- 2013: 0:02:53
- 2014: 0:04:19
- 2015: 0:05:46

**Inability to Respond**

- 2011: 0:00:00
- 2012: 0:01:26
- 2013: 0:02:53
- 2014: 0:04:19
- 2015: 0:05:46

**Square Miles**

- 1.2

**Population Density (0-7500)**

- 4,983

**Map**

- NORTHERN DUTCHESS: 25 Miles, 37 Minutes
- MHRH - VBMC: 8 Miles, 13 Minutes
- ST LUKES: 11 Miles, 18 Minutes
- SHARON: 38 Miles, 56 Minutes
- PUTNAM: 30 Miles, 39 Minutes

**Legend**

- BLS EMS
- BLS FIRE
- ALS Commercial
- ALS Municipal

**Summary**

- Population: 5,522
- Square Miles: 1.2
- Population Density: 4,983
• Transcare Ambulance ceased operations on February 26, 2016.

• Town of Amenia contracted with NDP for 24 hour coverage effective January 1, 2017.

• Arlington Fire District began ALS first response on January 1, 2017, contracting with Mobile Life Support as their transporting agency.
Dutchess County EMS calls per year:
2011: 27,198
2012: 27,832
2013: 28,002
2014: 28,624
2015: 30,546
2016: 31,903 (not included in the data)
Agency Alarm Data

"The data used for these graphs were derived from only the primary EMS provider in each district ."
The following pages present the data gathered by the Task Force, compiled and summarized as explained in the EMS System Data and Analysis section. The Task Force arranged the following pages alphabetically by township and then by agency within the township. Any abbreviations within the following pages correlate as follows:

- 14024 City of Poughkeepsie
- AMFD Amenia
- ARFD Arlington
- BEFD Beekman
- BNFD City of Beacon
- CHFD Chelsea
- CPFD Castle Point
- DEC NYS DEC Property
- DJFD Dutchess Junction
- DOFD Dover
- ECFD East Clinton
- EFFD East Fishkill
- FAFD Fairview
- FIFD Fishkill
- GLFD Glenham
- HIFD Hillside
- HPFD Hyde Park
- HUFD Hughsonville
- LAFD Lagrange
- MBFD Millbrook
- MIFD Milan
- MNFD Millerton
- NHFD New Hamburg
- NKFD New Hackensack
- PAFD Pawling
- PPFD Pine Plains
- PVFD Pleasant Valley
- RBFD Red Hook
- RMFD Rombout
- ROFD Roosevelt
- SBFD Staatsburg
- STFD Stanford
- TIFD Tivoli
- UVFD Union Vale
- WAFD Wappinger
- WCDF West Clinton
- WPFD Wappingers

The committee provided notes within each of the following pages, to assist the reader in understanding the complex and diverse nuances among the various townships and agencies and how they address the provision and delivery of emergency medical care.

Infographic Key of Symbols:
- HOSPITAL
- EMS Basic Life Support Agency (Squad or Corp)
- EMS Basic Life Support Agency (Fire Department Based)
- EMS Advanced Life Support Agency (Commercial)
- EMS Advanced Life Support Agency (Fire Department Based)
DUTCHESS COUNTY COMPARISON of TIMES (average 2011 – 2015)

From time of dispatch to arrival of Ambulance at scene

From time of dispatch until Ambulance is available for next call

CHFD performed by Beacon Volunteer Ambulance Corps
CPFD performed by Transcare
DEC performed by Beacon Volunteer Ambulance Corps
DJFD performed by Beacon Volunteer Ambulance Corps
GLFD performed by Beacon Volunteer Ambulance Corps
HIFD performed by Northern Dutchess Paramedics
HPFD performed by Northern Dutchess Paramedics
HUFD performed by Wappinger

RMFD performed by Mobile Life Support Services
SBFD performed by Northern Dutchess Paramedics
WPFD performed by Mobile Life Support Services
DUTCHESS COUNTY COMPARISON of ALARM NUMBERS (total count 2011-2015)
DUTCHESS COUNTY COMPARISON of ‘INABILITY TO RESPOND’ (2011-2015)

ITR AS A PERCENTAGE OF ALARMS

ITR AS A COUNT OF ALARMS

It should be noted, at no time did our data indicate a call went unanswered. If an agency could not respond another agency had to respond to the scene.