Texas EMS Alliance Testimony
Appropriation Subcommittee on Article II & House Committee on Public Health
July 13, 2016

Study the trauma system in the State of Texas including financing, service delivery, planning, and coordination between Emergency Medical Services providers, Trauma Services Area Regional Advisory Councils, The Emergency Medical Task Force, and hospitals. Determine strengths and weaknesses including challenges for rural areas of the state. Make recommendations to reduce any duplicated services, improve the coordination of services, and advance the delivery of trauma services in Texas.

Presented by: Dudley Wait | President, Texas EMS Alliance

Thank you for the opportunity to testify in front of these two committees. My name is Dudley Wait. I am a paramedic and have served in a variety of roles in all types of EMS agencies across my thirty-year career. I currently serve as an Executive Director for the City of Schertz and am responsible for all of public safety including fire, police, and EMS. Additionally, I currently serve as the Chair of the Governor’s EMS and Trauma Advisory Council’s EMS Subcommittee. I am also the Treasurer for the Southwest Texas Regional Advisory Council for Trauma (known as STRAC), and serve as their Pre-Hospital Committee Chair.

I am here today representing the Texas Emergency Medical Services Alliance (TEMSA) as the President of the Board of Directors. At the end of the 2013 Texas Legislature, several EMS leaders came together to create a collaborative public policy voice for agencies that have demonstrated their commitment to serving our communities across this great state. TEMSA membership accounts for almost 10-percent of all licensed EMS agencies providing 9-1-1 and inter-facility services to both urban and rural areas across Texas. Additionally, our membership represents all of the EMS models that will be discussed later.

I am testifying today on the portion of this Interim Charge related to EMS providers. We appreciate the committees taking up this charge, and would like to take this opportunity to provide information about the unique nature of our state’s EMS delivery system. We want to offer some potential public policy solutions for the 85th Texas Legislature for
your consideration to ensure that Texans continue to have access to outstanding ambulance services.

The Cost of Readiness: Unique Financial Challenges that Texas EMS Agencies Face

EMS agencies either are, or should be, a vital part of every Texas community. Unfortunately, many of our Texas communities are struggling to keep their local EMS service funded. Every citizen of Texas expects to be able to pick up the phone, dial 9-1-1, and receive high quality emergency medical treatment. However, there is currently no revenue source for EMS that provides compensation for providing that “state of readiness.”

EMS is a unique segment of the state’s healthcare system. EMS is typically utilized as the first entry into the healthcare system. From a clinical standpoint, an EMS agency is the only type of healthcare provider that is licensed to respond to the location of a patient suffering from an acute onset of illness or traumatic injury, provide patients with initial care on scene, and offer timely access to specialized segments of the healthcare system, such as a trauma hospital or stroke center. From a financial standpoint, the hundreds of EMS providers in our state utilize over a dozen different financial models to help ensure that they can hopefully be ready to meet their community’s needs.

It is a common misconception that ambulance transportation is a free and essential public service whose cost is completely covered by local taxes like those of police and fire departments. Tax funds do not cover the full cost of providing EMS services to a community. As a result, it is up to the EMS agency to cover the shortfall through billing the users of the system, or even going to greater lengths when patient billing does not provide enough revenue. This sometimes results in EMS agencies turning to fundraisers such as barbecue dinners and pancake breakfasts to keep the lights on and the trucks running.

Additionally, the financial model for ambulance reimbursement is a flawed fee-for-service model. An ambulance provider is only reimbursed by insurance, Medicaid, or Medicare if they transport a patient to a hospital. This has resulted in a pre-hospital system where we utilize the most expensive mode of transportation (an ambulance) to take patients to the most expensive place to receive healthcare (a hospital emergency department). In our current environment of increasing value, improving the patient experience, and decreasing costs, this model has become antiquated and is potentially fatal for ambulance organizations across the state.

Some examples of how this flawed model results in excessive costs include:

1. Patients being transported who could be appropriately treated by paramedics at the scene and released to follow up with their primary care physicians. An example is a known diabetic patient whose blood sugar is too low,
often results in a transport to the hospital where the patient is quickly evaluated and released.

b. Patients who could appropriately be cared for by their physician or at a minor emergency clinic for injuries and conditions such as a simple arm fracture, an episode of gout, or the flu. Instead, these patients are transported to an emergency department where an x-ray is taken or labs are run, and then the patient is released to follow up with an orthopedist or personal physician in their office.

In a better designed reimbursement system, ambulance providers could become an active partner in patient destination and treatment management, instead of just taking everyone to the hospital, even when that is not in the patient or the healthcare system’s best interest. I will highlight some new models that address these issues later in the written testimony.

In regards to current reimbursement, Texas EMS agencies typically rely on four different revenue sources to cover operation costs, and they include:

**Billing the Patient:**

When transported to a hospital, the EMS agency bills the patient for the service. However, since the cost of readiness often far outweighs the revenue generated by billing, such revenue is rarely enough to cover the entire EMS agency’s operations. This funding model attempts to put more of the cost of providing EMS on the actual users, instead of all taxpayers in the community.

However, billing the patient is also problematic due to the often low rates paid by both commercial and government (Medicare and Medicaid) health insurance plans. Numerous studies show that Medicare reimburses ambulance providers substantially less than the cost of providing services. Texas Medicaid rates are even lower at approximately 30-percent of the prevailing Medicare rate.

Meanwhile, commercial health insurance payments are highly variable, both in payment rates and in processing time. Frustrating to both patients and ambulance providers, some commercial health insurance plans make a very small payment, which leaves the remainder of the bill for the patient to be responsible for out of pocket. Often commercial health insurance plans attribute this to the 9-1-1 ambulance provider not being an in-network provider, yet several insurance providers have no in-network ambulance providers anywhere across the state. Furthermore, in an emergency situation, the patient does not have the opportunity to “choose” an in-network provider.

**Local Tax Funds:**

If billing the patient does not meet the total cost of providing the service, EMS agencies often must rely on local taxpayer dollars, if available, to cover its shortfall. The use of
these tax funds is a local decision, which creates a wide variability in their availability across the State.

In addition, EMS agencies are expected to be ready at all times and respond to every emergency, even if a patient is not transported to a hospital. The “cost of readiness” expense is the largest cost to an EMS agency and includes having staff on duty, vehicles stocked and ready, and other operational factors such as dispatch functions and administrative logistics. These expenses are not billable unless the patient is transported.

**Federal and State Grants:**

The state and federal government funding of EMS operations is extremely limited. In Texas, the Dedicated Tobacco Fund, which has almost been exhausted due to a change in law during the 2011 special session on education, provided monies for EMS agencies through Local Project Grants, which allow for the purchase of capital assets and life-saving equipment such as AEDs, cardiac monitors, ambulances, stretchers, and enhanced clinical training for EMS personnel.

In addition to the dwindling tobacco dollars, we have limited funding from the Driver Responsibility Program, which offers EMS agencies that participate with their RACs to capitalize on this program. While the funds are small, they are critical to EMS agencies all over Texas in their struggle to survive.

Unfortunately, Federal grant funds for EMS are extremely rare.

**Community Fundraisers:**

Many EMS agencies in our rural communities are forced to rely on creative fundraising events to help provide revenue for the EMS service. It is not uncommon to hear of Spaghetti dinners, Pancake breakfasts, or even raffle drawings to help cover costs. Occasionally, a community will have a local philanthropic trust or organization that may contribute to the EMS service. Although these funds may be small, scores of EMS services rely on this as well as countless hours from volunteer personnel to continue doing business.

**Each EMS Agency Is Different**

Fewer than 800 entities are licensed by the Texas Department of State Health Services to provide EMS service to Texas communities. However, each EMS provider may have a specialized skill-set specific to their community or mission:

A. Agencies may specialize in responding to 9-1-1 calls by responding to a patient’s acute onset of symptoms and transporting them to an appropriate hospital.

B. Agencies may specialize in continuing care in which an ambulance transfers a patient from a lower level of care to a more specialized setting. An example may
be an ambulance transferring a patient from a rural hospital to a more specialized urban facility. Some of these agencies may also be the 9-1-1 provider or serve as a back-up to the community’s primary 9-1-1 EMS provider.

C. Agencies may provide critical care transfers from a hospital to a specialized hospital. These agencies require a higher level of training and equipment to provide continuity of care for patients in critical conditions who already have received intensive care and must have that care continued during transport.

D. Agencies also often have specialized roles such as: Special Rescue Teams, Tactical Medicine Teams, or Event Medicine teams that provide medical services at large scale events or sport venues.

E. Many agencies in Texas provide all of these services, and more.

Texas is such a large and diverse state that each community utilizes a different model for delivering 9-1-1 services to its citizens.

The following is a look at the different EMS models utilized by Texas communities.

A. The Fire Department Model. Some communities have its EMS operations as a part of the community’s fire department. The cities of San Antonio, Dallas, Houston, Lewisville, and Flower Mound are examples.

B. The Government Owned and Operated EMS model (3rd Service). Some EMS entities within communities operate as an independent agency within the local government (City, County, Emergency Services District, Hospital District, etc.) and are separate from the fire department. This is called a 3rd Service EMS agency in which the city has three services: a police department, a fire department, and a separate EMS department. Austin/Travis County EMS and the City of Schertz EMS are examples.

C. Contracted EMS. Some cities or counties may contractually outsource the 9-1-1 ambulance function to a private EMS company. Bastrop County and Bexar County contract with Acadian Ambulance and the city of Tyler contracts with East Texas Medical Center EMS to provide their ambulance services.

D. Chartered or Private EMS agency. Other counties or cities may collaborate with an EMS agency, which is a non-profit (often originally formed as a volunteer organization), to provide EMS services to fulfill the community’s needs. Harris County Emergency Corps, which was founded in 1927 and served as Texas’ first EMS agency, provides EMS 9-1-1 service in north Houston for over 400,000 people. Angleton Area Medical Corps in Brazoria County is another example.
E. **Hospital-based EMS.** In some communities the EMS service is an extension of the local hospital. Coryell Memorial Healthcare System in Gatesville, Texas is an example of this type of system.

F. **A Multitude of other models.** Across Texas, communities provide EMS in different models as diverse and different as Texas is itself. The adage “If you have seen one EMS system, you have seen one EMS system” is very true in Texas.

**Clinical Advances in EMS**

Recent advances in the fields of trauma, septic shock, heart attack and stroke care have resulted in countless saved lives. EMS serves as the front line health care provider for both these and many other life-threatening conditions. The ability of EMS professionals to provide initial care and assessment during initial contact and to provide continuity of care during transport to a hospital gives the patient the best chance for a favorable outcome.

When symptoms of a heart attack begin to present, cardiologists recommend that a patient call 9-1-1 instead of driving themselves to a hospital. EMS professionals have the ability to begin treatment immediately in the field, which reduces the potential irreversible damage to the patient’s heart muscle. EMS professionals can assess the patient’s vital signs and cardio electrical activity and trigger the cardiac catheterization lab at the hospital. Research finds that patients who have access to an angioplasty within 90 minutes of first medical contact typically have the best outcomes. Without the early assessment, treatment, and activation by EMS, reaching this 90-minute window is often impossible.

While EMS clinical capabilities are evolving and saving patient lives, the EMS payment system has remained stagnant for decades. With limited exceptions, EMS agencies are only paid if the ambulance ultimately transports a patient to a hospital emergency department.

This creates a system wherein it is in the best interest of the EMS service to transport a patient to the most expensive care source – an overcrowded hospital emergency department – to be seen by a physician who does not know the patient and may not have access to the patient’s records. A recent article in the Journal of the American Medical Association stated that although EMS represents less than 1-percent of healthcare expenditures, they drive 23-percent of healthcare expenditures. EMS should be empowered to pursue finding alternative medical options that are ultimately in the patient’s and the healthcare system’s best interests, without hampering the agency’s ability to collect revenue. This issue is being recognized at the Federal level as well. The National Academies released a June 2016 report that recommended, among other things, the modification of the Centers for Medicare and Medicaid Services (CMS) ambulance fee schedule to recognize the new capabilities of EMS agencies.
Ironically, EMS providers’ advances in clinical care may hurt their reimbursement in some situations. With better training, paramedics are able to treat more patients at the scene, which results in no hospital transport. While the overall health system saves money due to the lack of a hospital visit, EMS providers ultimately lose money because they are only paid when they transport to the ER.

EMS agencies face a variety of costs associated with responding to 9-1-1 calls including a state of readiness which involves unit availability, personnel, fuel, ambulance maintenance, insurance, and a multitude of other factors. This readiness cost, as well as the costs of supplies and time used to treat patients, is not reimbursed when a patient waives hospital transport.

To help improve patient outcomes, improve the patient’s care experience, and reduce healthcare expenditures, the Legislature should work with healthcare stakeholders to allow the testing of innovative economic models for EMS, moving away from the misaligned incentive of using the most expensive transportation mode, (an ambulance) to take the patient to the most expensive treatment destination (an emergency department).

These new models could include payment for the response to the scene versus the actual transport, in the form of capitated payments or payment for delivery models that prevent an ambulance response, such as 9-1-1 nurse triage programs, and community paramedicine. While these models still do not pay for the cost of readiness, they do provide revenue streams outside of transport, which will further incentivize EMS agencies to do what is best for the patient, even if that is not to transport them at all.

Some healthcare stakeholders, such as commercial health insurance plans, are recognizing the value of EMS agencies’ non-emergency services and incorporating these into new health care delivery models. The programs, which consist of EMS agencies joining with community healthcare partners to improve outcomes and reduce costs, are often referred to as community paramedicine programs. Texas is home to some of the most innovative models.

MedStar Mobile Healthcare is the ambulance service provider for Fort Worth and 14 other Tarrant County cities. As the EMS provider for more than 938,000 people in the greater Fort Worth area, MedStar sees the value of the 9-1-1 system for medical and trauma conditions that, for the patient's benefit, could best be addressed by a response other than an ambulance trip to an emergency department. In July 2009, MedStar implemented the Mobile Integrated Healthcare (MIH) program that identified high system users and developed individual care plans for each of those patients. Through the MIH program, MedStar is exploring a number of novel approaches to healthcare including providing surgical preparation coordination, directing patients to primary care rather than to the emergency care system, medication reconciliation, and a number of other programs. MedStar is considered one of the national leaders in the area of MIH and community paramedicine.
Higher Education related to EMS

In 2013, The Department of State Health Services began following the national recommendations requiring accreditation for all paramedic education programs. This process has elevated the educational requirements for paramedics so that they are equal to, and sometimes greater than, that of registered nurses. However, it did have the unintended consequence of limiting the number of available paramedic programs, especially in the rural areas of Texas. Exhibit A, at the end of this testimony shows the number of Paramedic training programs in Texas in March, 2011. Exhibit B shows the number of Paramedic programs that exist today in 2016. These exhibits clearly show a 20-percent decrease in the availability of Paramedic training programs across the state with many of the decreases in the more rural and frontier locations. A number of non-college based educational entities and some community colleges elected to end their Paramedic programs in 2013 as they did not have the personnel or funding to go through the accreditation process, or they did not see the program as being break-even or profitable. As you will hear later, this is resulting in a larger shortage of paramedics in the underserved rural and frontier areas of Texas.

Currently there are only a few national undergraduate degree paramedic programs, which tend to focus almost exclusively on management, not on clinical care. There currently are a very limited number of options for paramedics to take their paramedic education and experience and move further into the healthcare system. The 84th Texas Legislature’s action that allowed paramedics to work under the supervision of a physician in hospital emergency departments was an important step to offer another career path for Paramedics.

Workforce Challenges

The number of quality EMS professionals is a challenge throughout Texas. This is especially true in the rural areas of the state. The Panhandle RAC recently performed a study that showed alarming demographics regarding the increasing age and decreasing number of paramedics in that region. I think you will find the information about the demographics in our rural regions presented by the second panel of speakers to be quite informative.

In addition, EMS agencies across the state are constantly challenged to compete for healthcare recruits that may also be considering other allied healthcare professions with similar lengths of education requirements, but result in higher wages such as nursing, radiology, and phlebotomy. The current 2-year education requirement to become a paramedic also forces EMS agencies to compete with industries that may require a shorter education process and provides a higher income such as jobs in information technology and other traditional trades. In addition, in the rural and frontier areas of Texas where volunteers are relied upon to staff ambulances every day, the increased requirements of paramedic education make it extremely difficult for someone to invest two years of time just to volunteer to help their local communities.
Besides relatively low wages and current education requirements, we believe that other major challenges we face in recruiting more students into EMS is the currently limited number and types of career paths in EMS, as well as the perception that EMS is only a transport provider, rather than a bona fide part of the healthcare system. These are issues that we continue to work on as an industry in order to provide more opportunities to our workforce.

Finally, EMS is losing highly experienced and qualified paramedics due to the effects of high levels of stress and a lack of recognition of Post Traumatic Stress Disorder (PTSD). EMS leaders who are struggling to pay the cost of readiness, recruit, train staff, and maintain daily operations often miss the signs and symptoms of PTSD. Unfortunately, when it is recognized, the EMS agency likely has no means to assist their staff other than to encourage them to utilize their healthcare benefits to seek help. As a result, across our state and nation, we are seeing increased levels of EMS employee suicide attempts, suicides, and substance abuse issues. EMS agencies need to be provided with resources available across the state to help combat this slow debilitating illness.

**Issues Specific to Rural EMS Agencies**

Rural EMS agencies throughout the state face some of the most difficult challenges related to funding, workforce, education, and providing response to vast areas of Texas. Often rural EMS agencies cover hundreds of square miles of response areas, with limited staff who are overworked and underpaid (or not paid). Patients often have to be transported over a hundred miles to be treated appropriately, leaving the community with less (and sometimes no) EMS coverage for hours while the transporting unit is on the road, in addition to the lengthy times that volunteers are away from their paid jobs and families.

Rural communities often face the challenges of recruiting staff to live and respond in their community, as well as finding the means to educate those that wish to become paramedics. Many rural EMS agencies rely heavily on volunteer on-call responses to provide EMS care, which, when compounded with the limited educational availability, often leads to a small number of staff that are responsible for providing care constantly to the community. Some of these volunteers spend days or even weeks at a time “on call” because there is simply no one else available to respond.

**Key EMS Issues in the 85th Texas Legislature**

Over two dozen issues had a direct impact on our state’s EMS agencies in the 84th Texas Legislature, and we expect a similar level of EMS-related bills in the upcoming session. We realize that revenue will be extremely limited in the 85th Texas Legislature, therefore, we are focusing on several priorities that will enhance the operations of Texas’ 9-1-1 providers and not result in large expenditures from the state.
Ambulance Fuel Tax Relief for 9-1-1 Services
The 84th Texas Legislature took an important step in the right direction to provide financial relief to EMS agencies through an effort that provides fuel tax relief for non-profit EMS agencies. (HB 2731 was amended to HB 1905, which was signed into law.) The Legislative Budget Board estimated that it will only result in a loss of approximately $92,000 to the state’s Available School Fund in 2016.

We encourage the 85th Texas Legislature to consider expanding the motor fuel tax relief to all agencies that provide 9-1-1 services. HB 3468 was an example of model legislation in the 84th Legislature. Had it passed, HB 3468 would only have resulted in a loss of $501,000 to the general revenue in 2016.

Saving the Tobacco Fund and Other Emergency Healthcare Funds
As others will testify today, the Tobacco Fund has been depleted and will no longer be able to provide the grants or pass through dollars to EMS agencies. The Texas EMS Alliance is asking the 85th Texas Legislature to ensure that the funding for EMS Local Project Grants are at least maintained at their current level of $1.3M annually and that a plan be developed to expand this grant program in excess of $5M annually. This could be done by utilizing other grant funds across related state agencies, or by allocating an additional $5M of the dedicated EMS licensing and certification fees to DSHS with the sole purpose of expanding the Local Project Grant program.

The Alliance is also asking that the 85th Texas Legislature provide appropriate funding for all twenty-two Regional Advisory Councils (RACs). The bulk of RAC funding was previously allocated through the interest from the dedicated Tobacco Fund. This minimal funding has not changed significantly since the fund was established in the late 1990s, but the requirements of the RACs have increased dramatically. With the demise of the dedicated Tobacco Fund, RAC funding is in danger of disappearing completely.

The RACs are critical to the success of the emergency healthcare system. With all the difficulty in managing the day to day operations of an EMS agency, imagine each of the almost 800 EMS agencies having to coordinate with over 300 hospitals in managing destinations and treatment protocols for trauma, cardiac, stroke, and other acute care patients. The RACs are the lone entities that bring all players in the emergency healthcare system to the table for regional planning, destination management, process improvement, and injury prevention. The overall success of a statewide EMS system is incumbent upon the success of the RAC system.

Draw Down Additional Medicaid Dollars at No Additional Cost to Texas
Over the last several years, Texas has implemented a cost reimbursement program for governmental ambulance providers. This program allows municipal and county ambulance providers to receive additional dollars for transporting Medicaid and uninsured patients. Unfortunately, this option is not available to non-governmental ambulance providers that are providing 9-1-1 services across Texas. We recommend that the 85th Legislature follow the lead of other types of healthcare providers in the state and draw down additional federal dollars at no cost to the state by maximizing the Medicaid
match. It is possible to identify local expenditures that could qualify for a federal match through an intergovernmental transfer (IGT). The Texas EMS Alliance desires to partner with the Legislature to develop a low impact, high result plan that would allow all providers of ambulance service to receive additional cost reimbursement for Medicaid and uninsured patients.

**Protecting the Ability of an EMS Agency to Bill a Patient**

While we recognize that these committees do not have jurisdiction over commercial insurance issues, we do believe that it is important to educate the entire Legislature about the need to protect the ability of EMS agencies to bill a patient for out-of-network services. As mentioned earlier, local taxpayer funds and bills sent to patients provide the greatest source of revenue to cover an EMS agency’s operations. If the Legislature eliminates the ability of EMS agencies to balance bill a patient for out-of-network services, local communities will be forced to raise taxes in order to cover the EMS operations.

As we, as an industry, continue to work with commercial health plans to ensure network adequacy of EMS providers and improve healthcare plan coverage of EMS, we are mindful that any costs not covered by the health plans must be covered by the people who use the EMS service, or the taxpayers. Ultimately, the local governmental bodies would prefer to see the cost be placed with the actual users, instead funded through tax subsidies. The ability to balance bill is key to preserving this model. It is also important to note, that unlike virtually any other healthcare provider, EMS must have authorization from a local governmental agency in order to operate in that jurisdiction. Thus, each local government has authority over the EMS agency, and often specifically regulates the billing practices of that agency.

**Assisting and Protecting the EMS Workforce**

The war on terrorism has brought a greater awareness to the forefront, of the dangerous and debilitating effects of Post-Traumatic Stress Disorder (or PTSD), suffered by our war fighters. This has evolved into a greater awareness of these same effects on the EMS workforce, as well as other First Responders. Besides workforce shortages and challenges mentioned previously, the damaging effects of cumulative stress created by responding shift after shift to scenes of senseless violence and carnage from traumatic accidents, or untimely deaths, has a profound effect on the EMS workforce. In times past, I would have told you that after 30 years of EMS I had no long-term effects from all the years of responding to people on their worst day; but after seeing a presentation on PTSD by Brian Eastridge, MD from University Hospital, that he bravely presented after six deployments oversees with the U.S. Army, it became painfully obvious how PTSD had actually changed me.

Discussing this with other EMS leaders, it has become obvious that we need to be proactive regarding our personnel and this issue. The signs of PTSD are alarming as you look across our workforce. Increased suicides and suicide attempts, increases in medication diversions and substance abuse, and the “results” in personal lives of doing the job that we all thought were normal (divorce, relationship difficulties, illness, etc.),
demonstrate that we need to start taking steps to educate, protect, and treat our current workforce to help them recognize and avoid the destructive behaviors that are a part of PTSD.

We believe Texas should take the lead on this issue and establish the Texas EMS Personnel Resiliency Center. This “Center” would begin by developing an EMS Peer Assistance Program to take immediate steps to curb substance abuse and drug diversions in our ranks across the state. In addition, the Center would provide resources and scientific based resiliency program templates for EMS agencies to adopt across the State to support our efforts on combating this devastating condition.

**Conclusion**

The Texas EMS Alliance is grateful to the committees for the opportunity to testify in regards to this interim charge and share our insight on the EMS industry. We are honored to represent the EMS communities in Texas and we thank you for your consideration and support. We look forward to working alongside the Legislature in the upcoming session to continue to strengthen EMS care for the citizens of Texas.

**Witness Contact Information**

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EXHIBIT A
Texas Paramedic Programs – March 2011

Texas EMS Paramedic Programs Accreditation Status

Paramedic Programs
- Accredited
- Requested
- Working
- No Plan
- Transition

Source: Office of EMS/Trauma Systems/Regulatory Services
Map Source: Center For Health Statistics, GIS
March 2011
EXHIBIT B

Texas Paramedic Programs – June 2016