

Oral Testimony of James T Kerr

NYC EMS: A Systemwide Management Response

James T. Kerr | Former Executive Director, New York City EMS (1980–1988)

Remarks to the New York City Council • October 20, 2026

Nearly four decades have passed since I left New York City EMS. Much has changed during that time, yet many of the underlying challenges remain. The testimony presented at this hearing reinforces a fundamental point: prolonged ambulance response times are not an isolated problem. They are a symptom of broader weaknesses in the emergency medical services system.

The Mayor must take responsibility for bringing the appropriate agencies and stakeholders together to address those weaknesses. Some of the issues discussed at this hearing are within the Fire Department's control, but many are not. FDNY cannot resolve them on its own; it needs the active participation of other City agencies, EMS labor, and the hospital community.

I therefore recommend establishing a Mayor-directed EMS Improvement and Modernization Task Force, bringing together FDNY, the Office of Management and Budget (OMB), the Office of Labor Relations (OLR), EMS labor representatives, NYC Health + Hospitals, and the broader hospital community. Its purpose should not be to assign blame, but to develop coordinated, practical solutions to the problems affecting EMS performance.

Workforce stability must be central to that effort. EMS personnel need competitive compensation, including consideration of pay parity with firefighters. Rising call volume also requires more personnel. Although the system has approximately 4,500 budgeted EMS positions, only about 4,150 personnel are currently on board. Filling those vacancies is important, but the staffing requirement should not be assumed to end at the existing budgeted headcount.

Emergency medical call volume has increased substantially—by approximately 41% since the 2010s, as discussed today—without a comparable increase in staffing resources. That mismatch deserves a systematic examination rather than an assumption that existing staffing levels are adequate.

Within 90 days, the Task Force should submit an implementation plan establishing clinically appropriate response-time targets, identifying the staffed ambulance capacity and operational improvements needed to achieve them, and specifying the resources required and the agencies responsible for implementation.

Performance should be measured by the percentage of patients reached within those targets, not simply by average response time. For example, a standard calling for an advanced life support (ALS) unit to arrive within six minutes in 95% of applicable cases would reveal far more about reliability than an average of ten minutes. Averages can conceal dangerously long waits. The concern is not merely an occasional outlier, but the frequency of those extended responses.

A systemwide problem requires a systemwide management response.

New York City has the data, expertise, and technology to improve EMS performance. What is needed is a coordinated mechanism to turn that knowledge into action.

The objective must be faster, more reliable access to appropriate emergency care and better patient outcomes.

Written Testimony of James T Kerr

Former Executive Director, New York City EMS
President, KERR Associates, Inc.

Before the New York City Council
Committee on Fire and Emergency Management
Committee on Hospitals

Oversight Hearing: Ambulance Response Times
October 20, 2026

Chairpersons and members of the Committees:

Thank you for the opportunity to testify concerning ambulance response times. I will first examine the principal issues affecting timely and reliable EMS care, then propose how the City can address them through coordinated operational improvements and accountable implementation.

I served as Executive Director of New York City EMS from 1980 to 1988 and have spent much of my subsequent career managing healthcare operations in both the public and private sectors.

Much has changed since I left EMS almost 40 years ago, but many underlying challenges remain familiar: meeting demand, maintaining staffed ambulance capacity, recruiting and retaining skilled personnel, deploying resources effectively, and returning ambulances promptly to service after patient transfer.

Response time is the symptom of these larger system issues—not the problem in isolation.

EMS response reflects the performance of an entire system, beginning when someone calls 911 and continuing through call processing, dispatch, assignment of an appropriate unit, staffed ambulance availability and deployment, travel to the patient, treatment and transport, patient transfer at the receiving hospital, and the ambulance's return to service.

The challenge before the Council and Administration is therefore broader than reducing a single average response-time number. I believe the City should address three fundamental questions:

What clinical and operational performance should New Yorkers expect from their emergency medical system?

Where along the 911-to-patient-care continuum are delays, capacity constraints and system vulnerabilities preventing those expectations from being met?

What resources, operational improvements and interagency actions are necessary to close those gaps reliably?

The following sections use selected performance findings to identify the questions the City must answer. They then set out recommendations for improvements in workforce stability, hospital turnaround, deployment and time-critical care, followed by a proposed structure and timetable for implementation. Supporting historical figures are retained in the appendix.

What the Current Data Tell Us

The Fiscal Year 2026 Mayor's Management Report covers July 1, 2025 through June 30, 2026. Its annual response-time measure establishes the scale of the problem.

The City's data show that the end-to-end average ambulance response to life-threatening medical emergencies increased from 11 minutes 21 seconds in FY2025 to 13 minutes 9 seconds in FY2026—an increase of 1 minute 48 seconds in a single year.¹

The annual figure above already measures end-to-end ambulance response, including the time before the ambulance begins travelling. It is not a measure of travel time alone. To identify where improvements are needed, the City should examine the separate stages within that total: call receipt and processing, transfer to FDNY EMS, dispatch and unit assignment, turnout, and travel.²

For the patient, however, the most important question is straightforward:

How long does it take from the call for help until appropriate clinical care reaches the patient?

The worsening response-time figures should therefore be treated not simply as an ambulance travel problem, but as an indication that the City should examine the entire system that produces them—including emergency communications and call processing, staffed ambulance capacity, workforce availability, deployment, traffic and geography, patient-transfer delays at receiving hospitals, and the availability of appropriate clinical resources.

The New York City Comptroller's October 16, 2026 report, *A System Under Strain: FDNY EMS Operations and Fiscal Pressures*, provides additional independent evidence of sustained pressure. It reports that average ambulance response time to life-threatening emergencies rose by 3 minutes 50 seconds (41.2%) between FY2015 and FY2026, while non-life-threatening response time increased by 14 minutes 49 seconds. Over the same period, life-threatening incident demand increased by 22.9%. These long-term trends reinforce the need to examine the complete system rather than a single response-time component. The Comptroller also identified differences among official response-time series. For FY2026, the Mayor's Management Report and the Comptroller's NYC Open Data calculation report 13:09 for end-to-end life-threatening ambulance response, while the Local Law 119 series reports 13:16. The City should reconcile reporting definitions, included incidents and denominators, and publish those definitions alongside comparisons.³

September 2026 Local Law 119 data show why geographic reliability also matters. Average life-threatening ambulance response ranged from 12 minutes 44 seconds in Brooklyn to 16 minutes 57 seconds in the Bronx. This measure runs from a report to a 911 operator to the arrival of the first ambulance.⁴

These figures identify performance gaps, but do not establish their causes. The September five-borough weighted average was about 15 minutes, essentially unchanged from June. The appropriate focus is persistent service reliability and the operational factors that shape it.⁵

¹ City of New York, Fiscal Year 2026 Mayor's Management Report, FDNY performance indicators, FY2025 and FY2026. The cited indicator is end-to-end average ambulance response to life-threatening medical emergencies.

² City of New York, 911 Reporting, incident and Local Law 119 category definitions: <https://www.nyc.gov/site/911reporting/reports/definitions.page>. See Appendix A2, Response clocks, and A3, Weekly performance, for examples distinguishing total response from individual stages.

³ New York City Comptroller, *A System Under Strain: FDNY EMS Operations and Fiscal Pressures* (October 16, 2026), <https://comptroller.nyc.gov/reports/a-system-under-strain-fdny-ems-operations-and-fiscal-pressures/>.

⁴ See Appendix A1, Borough ambulance response and September ALS performance, for the complete June, August and September comparison. NYC Open Data Local Law 119, CSV retrieved October 12, 2026: <https://data.cityofnewyork.us/Public-Safety/911-Open-Data-Local-Law-119/gpny-cuvw>.

⁵ NYC Open Data, 911 Open Data Local Law 119, downloadable CSV retrieved October 12, 2026; September monthly records. <https://data.cityofnewyork.us/Public-Safety/911-Open-Data-Local-Law-119/gpny-cuvw> Category definitions: <https://www.nyc.gov/site/911reporting/reports/definitions.page>

The Council's September 30 hearing on emergency response in geographically isolated communities further illustrates why geographic reliability and operationally available staffed units should be measured together. A transport outside a geographically isolated service area can temporarily reduce local coverage even when the ambulance remains part of the citywide fleet. The City should examine such coverage gaps using dispatch and unit-availability data rather than infer their frequency from anecdotes.

Define the Performance New Yorkers Should Expect

The annual average and September borough differences establish the need for improvement. The next question is what performance New Yorkers should expect and how consistently that performance is achieved.

Averages alone can conceal both good performance and extremely long responses.

The City should establish clinically appropriate response-time standards for defined categories of medical emergencies and report not simply average response time, but the number and percentage of responses that meet those standards.

The central questions should include:

What percentage of the most time-critical patients receive an appropriate clinical response within the established standard?

What percentage of other life-threatening emergencies are reached within their applicable standard?

What percentage of non-life-threatening emergencies are reached within their standards?

In September, only approximately 26% of emergencies included in the City's defined ALS measure received an ALS ambulance in less than ten minutes across the five boroughs. Fewer than one-third met that threshold in every borough. This illustrates the value of reporting the percentage meeting a standard, alongside average response time.⁶

The ALS percentage counts a particular group of serious emergencies that require a paramedic ambulance. It does not count every life-threatening emergency. Therefore, 26% does not mean that only 26% of all life-threatening calls received an ambulance within ten minutes. Nor does this measure establish that ten minutes is the appropriate clinical target for every type of emergency.⁷

The City should build on its existing ALS reporting by establishing clinically appropriate standards for defined categories of life-threatening and non-life-threatening emergencies. For each category, reporting should identify the appropriate responding clinical resource, define the response clock, and show the percentage meeting the standard together with the median, 75th and 95th percentiles. Results should be reported citywide, by borough, tour or demand period, and at the community board level where statistically reliable. Clinical and operational review should determine the thresholds.⁸

These measures answer two practical questions:

How often does EMS meet the expected standard?

When it does not, how severe are the delays?

⁶ See Appendix A1 for September borough percentages, A5 for the August ALS breakdown, and A8 for the weighted calculations. These calculations use the ALS incident counts for this specific measure.

⁷ NYC 911 Reporting, Local Law 119 Category 9 definition: <https://www.nyc.gov/site/911reporting/reports/definitions.page>. The dataset labels the threshold as less than 10 minutes.

⁸ See Appendix A4, Response distribution, for an example showing why the average and median tell different parts of the response-time story.

Community board level reporting is necessary because borough averages can conceal differences within a borough. Where monthly incident counts are too small for reliable comparisons, the City should use rolling periods or minimum case thresholds.

The objective should be reliable performance, not merely improvement in the average.

Examine the Entire 911-to-Patient-Care Continuum

EMS response does not begin when an ambulance starts moving. It begins when a person seeks emergency assistance.

The City should therefore separately measure—and also examine end-to-end—the principal components of the response process:

911 receipt and answer;

call processing and transfer to FDNY EMS;

EMS call processing and dispatch;

unit assignment;

turnout and travel;

arrival of the first appropriate clinical resource;

treatment and transport;

patient transfer at the receiving hospital; and

return of the ambulance to service.

For each component, the City should determine where delay occurs, what causes it, and which City agency or participating organization has the authority and resources to address it.

Emergency communications and technology resilience should be part of this examination, including system redundancy, contingency procedures, real-time monitoring and escalation protocols.

The purpose should not be to assign blame among City agencies and participating organizations. It should be to manage emergency medical response as the end-to-end system experienced by the patient.

Use the City's Data to Diagnose the System

Much of the information needed for this analysis already exists, but it resides in different City agencies and participating organizations, including EMS labor and receiving hospitals.

FDNY possesses information concerning calls, dispatch, unit assignments, travel, staffing and ambulance availability. OMB has resource and financial information. The Department of Citywide Administrative Services (DCAS) should contribute information and expertise on recruitment, civil service processes and fleet support. OLR and EMS labor possess important workforce information and operational experience. Health + Hospitals, the Greater New York Hospital Association and individual receiving hospitals have information relevant to patient transfer and hospital turnaround.

These data should be brought together within a common analytical framework so that EMS can be examined as a single system rather than as a series of separate responsibilities of City agencies and participating organizations.

The analysis should determine:

demand by geography, time of day and clinical category;

scheduled ambulance-hours compared with staffed and actually available ambulance-hours;
capacity lost through vacancies, absences, staffing shortages and other workforce factors;
capacity lost through extended patient-transfer delays at receiving hospitals;
how deployment corresponds to actual and predicted demand;
which geographic areas experience the least reliable response;
the relationship between available staffed ambulance-hours and the percentage of calls meeting performance standards; and
how many additional staffed ambulance-hours—or what other operational changes—would be required to achieve those standards reliably.

The analysis should be performed citywide, by borough and, where statistically appropriate, at the community-board level.

The purpose is not simply to collect more data. It is to use existing information to identify causes, test solutions, allocate resources and determine whether those solutions actually improve performance.

Measure Actual System Capacity

A scheduled ambulance is not necessarily an available ambulance.

An ambulance without a complete crew does not provide operational capacity. An ambulance delayed at a receiving hospital during patient transfer is temporarily unavailable to answer another emergency. And an available ambulance located far from emerging demand may exist as capacity on paper while providing limited practical protection to patients in the affected area.

The City's analysis should therefore distinguish among scheduled, staffed and actually available ambulance-hours and quantify why capacity becomes unavailable.

The central resource question should be:

How many staffed and available ambulance-hours—and what supporting resources and operational improvements—are required to achieve the City's defined clinical and operational performance standards reliably?

That question connects resources directly to measurable performance rather than beginning with a predetermined fleet or staffing number.

Fleet availability should also be distinguished from operational EMS capacity.⁹

The Comptroller reported 360 ambulances in service on January 8, 2026, against a then-reported daily fleet-service target of 488, and 416 on September 14, 2026, following a reduction of that target to 332. The City should explain the operational basis for the revised target and distinguish fleet-service counts from fully staffed, deployed and immediately dispatchable 911 ambulances. Neither the target nor mechanical readiness alone establishes sufficient clinical coverage.

That distinction is critical. The City can have a sufficient number of mechanically available ambulances while still experiencing inadequate operational capacity because of staffing shortages, units committed to calls, hospital patient-transfer delays, or other factors.

⁹ See Appendix A6, Fleet readiness, for the distinction between mechanically available vehicles and staffed operational ambulance capacity.

EMS performance reporting should therefore separately identify scheduled ambulance-hours; staffed and in-service ambulance-hours; units actually available to accept assignments by borough, tour and demand period; units unavailable because of staffing or mechanical problems; units committed to incidents; and units delayed at hospitals or otherwise temporarily unavailable for another assignment.

The practical capacity question is:

How many fully staffed ambulances are actually available to respond when New Yorkers call 911, where are they located, and how does that availability change by time of day and demand?

The Council should obtain the latest monthly reports required by Local Law 30 of 2026 and reconcile them with CAD status records and staffed ambulance-hours. Administrative Code section 15-154 requires reporting, by borough and EMS unit type, of daily average units scheduled and unable to respond, with reasons for inability. These unit counts should be supplemented by measures of the duration and location of unavailable capacity.¹⁰

The Council's October 20 hearing will also consider Introduction 990-2026, which would require New York City Emergency Management, in consultation with FDNY, to issue an emergency notification when FDNY-EMS has more than 25 pending ambulance dispatches at any given time because there are insufficient in-service and available ambulances to respond. The proposal highlights an important operational condition: at times, demand can exceed immediately available ambulance capacity.

Whatever action the Council ultimately takes on that legislation, the underlying condition should also be incorporated into EMS performance management. The City should measure and publicly report the frequency, duration, time of day, geography and clinical priority of periods when ambulance requests remain pending because no in-service ambulance is immediately available, and analyze how those periods relate to staffed ambulance-hours, hospital turnaround, deployment and response-time performance. That information would help distinguish notification of a capacity problem from identification and correction of its causes.

Information requested for Council oversight

Additional questions raised by the Comptroller's October 16 report include: What analysis supported reducing the fleet-service target from 488 to 332? How many staffed and actually available ambulance-hours are required to meet clinically appropriate standards? How much capacity is lost through vacancies, internal career movement, mechanical downtime, hospital turnaround, dispatch delays and geographic coverage gaps?

I respectfully ask the Committees to obtain September staffed and actually available ambulance-hours by borough and tour; the latest Local Law 30 reports with reasons for unit unavailability; patient-transfer and ambulance turnaround times by hospital; and the number, duration, geography and clinical priority of dispatch backlogs, including periods exceeding 25 pending assignments. FDNY should explain differences in ALS threshold performance among boroughs and identify an accountable lead and timetable for connecting these operational data to response performance.

Stabilize the EMS Workforce

Ambulances cannot operate without EMTs and paramedics.

Recruitment, retention, compensation, career opportunity, working conditions and morale therefore have direct operational consequences.

¹⁰ <https://codelibrary.amlegal.com/codes/newyorkcity/latest/NYCAadmin/0-0-0-236615>

Workforce analysis should determine the effect of vacancies, attrition, absences, overtime dependence, internal movement to other FDNY career paths and compensation on the number of staffed ambulance-hours actually available.¹¹

Competitive wages are central to maintaining that capacity. The City needs compensation that can attract qualified applicants, retain experienced EMTs and paramedics, and make EMS a viable long-term career. Compensation should be evaluated alongside career opportunity, working conditions and morale as part of the operational plan.

When experienced personnel leave or positions remain vacant, fewer ambulance tours may be fully staffed, dependence on overtime may increase, and remaining employees may carry a heavier workload. Repeated recruitment and training also require time and resources. The City should determine how much these workforce losses reduce available ambulance-hours and whether compensation and retention improvements recover that capacity. Better wages should be part of a coordinated response that also addresses dispatch, deployment and hospital delays.

FDNY, OLR, OMB, DCAS and EMS labor should compare total compensation and career progression with the labor markets in which the City recruits and retains personnel. The assessment should include movement to other FDNY careers, reasons for separation, vacancies, time to hire and train, overtime reliance and the staffed ambulance-hours lost or recovered.

The implementation plan should identify the compensation and retention measures needed to sustain required staffing, their costs, and how results will be evaluated. Competitive compensation and pay parity should be examined explicitly, with success measured through retention, net staffing gains and reliably available ambulance-hours.

The Comptroller reported more than 500 departures from EMT titles in FY2026, equivalent to 19.5% of average EMT headcount. Of EMT and paramedic title departures, 58% and 45%, respectively, involved movement to firefighter titles; these should not be interpreted as separations from City employment. Its approximately \$289 million FY2027 estimate for firefighter-level EMS compensation is a modeled scenario under specified assumptions, not a negotiated agreement, and should be evaluated separately from other cost estimates.

An October 10, 2026 report in The Guardian, “‘People are leaving’: New York City’s EMS workers are struggling to make ends meet,” describes EMS workers’ concerns about compensation, retention and career sustainability. The article underscores why the City should evaluate competitive compensation and workforce stability as potential determinants of staffed ambulance-hours, rather than treating labor issues separately from operational performance.¹²

The objective should be to make EMS a viable and sustainable career while ensuring that the City can consistently staff the resources required to meet its clinical performance expectations.

Improve Hospital Turnaround and Recover Capacity

Hospital turnaround is also a system-capacity issue.

When an ambulance is delayed at a receiving hospital during patient transfer, that ambulance and crew remain unavailable for the next emergency.

¹¹ See Appendix A7, Recruitment and net capacity, for an example of why new graduates and promotions must be assessed alongside separations and other workforce losses.

¹² The Guardian, October 10, 2026, <https://www.theguardian.com/us-news/2026/oct/10/ems-workers-nyc-low-pay>.

FDNY, Health + Hospitals, the Greater New York Hospital Association and individual receiving hospitals should establish a coordinated approach to patient-transfer performance.

Turnaround should be measured by receiving hospital, time period and percentile, and by ambulance unit to identify units experiencing higher-than-average turnaround times. Comparisons should account for receiving hospitals and operating conditions. The City and hospital community should identify facilities, units and periods experiencing excessive delays, examine the underlying causes, establish reasonable performance expectations and implement interventions that return ambulances safely and promptly to service.

Even modest reductions in patient-transfer time, applied across a large volume of ambulance transports, could recover meaningful operational capacity.

Use Predictive Technology to Improve Deployment

Modern technology provides opportunities that did not exist when I managed NYC EMS.

Historical and real-time demand, ambulance availability, predicted travel times, traffic conditions and geographic coverage can increasingly be combined to improve deployment decisions.

Predictive deployment should be evaluated according to whether it increases the percentage of patients reached within established standards, improves geographic reliability and reduces unusually long response times.

Technology, however, cannot substitute for sufficient staffed capacity. Its purpose should be to ensure that available resources are positioned and used as effectively as possible.

Create a Targeted Ultra-Time-Critical Response Capability

Not every life-threatening medical emergency is equally time-sensitive.

For a narrowly defined group of conditions—including cardiac arrest, respiratory arrest or airway obstruction, certain unconscious or unresponsive patients, catastrophic hemorrhage, and anaphylaxis with airway compromise—the time to the first effective clinical intervention may be especially important.

The Council itself has recently recognized the importance of rapid lifesaving intervention in cardiac arrest. Resolution 653, introduced on September 24, 2026, emphasizes the importance of early CPR and automated external defibrillation and the relationship between rapid intervention and survival. That same clinical principle should inform how the City evaluates EMS response: for the most time-critical emergencies, an important measure is not simply when an ambulance arrives, but how quickly the patient receives the appropriate lifesaving intervention.

The City should evaluate a geographically limited Critical Response Team/Critical Response Vehicle (CRT/CRV) pilot.

A CRT would consist of a small, additional, appropriately trained clinical team operating a non-transporting CRV and strategically positioned using historical and predictive demand information.

This concept should be distinguished from FDNY's existing Paramedic Response Unit program. PRUs are also non-transporting paramedic units, but FDNY describes their role more broadly, including improving ALS availability by allowing ALS providers to transfer non-critical patients to BLS ambulances and return to service more quickly.

The City should evaluate the existing PRU program to determine whether it is meeting its objective of improving overall ALS unit availability. Evaluation should measure how quickly PRUs return to service after transferring care, the additional ALS availability achieved, the effect on ALS response performance, and whether staffing PRUs reduces availability elsewhere in the system. The assessment should use comparison areas and pre/post

analysis where feasible and distinguish the PRU program's broader availability objective from the CRT pilot's focus on time to critical clinical intervention.

The proposed CRT/CRV pilot would have a narrower and more explicitly clinical mission. It would be designed specifically for a carefully defined subset of emergencies in which the time to a critical intervention may directly affect outcome. Its deployment locations, dispatch criteria, staffing and performance standards would be designed around the objective of shortening the time to the first appropriate lifesaving clinical intervention, rather than primarily improving overall ALS unit availability.

Just as importantly, the CRT concept would be integrated from the outset with transport capacity. Every CRT/CRV dispatch would simultaneously generate the appropriate transport-ambulance response. The CRT would accelerate clinical care; it would not substitute for the ambulance required to continue treatment and transport the patient.

The CRT/CRV would therefore supplement—not replace—the transporting ambulance.

Within a small, carefully defined pilot area, the City could test an ambitious CRT arrival objective of approximately three minutes for qualifying incidents. This would be a pilot performance objective, not an assumed citywide guarantee. Coverage boundaries, deployment locations and dispatch rules would have to be designed and evaluated against that objective, with a paired transport-ambulance standard protecting continuity of care.

The experiment would require additional, dedicated staffing and funded coverage sufficient to preserve existing ambulance operations. Existing staffed ambulance units should not be eliminated, left unstaffed or reduced to supply personnel for the CRT. The pilot budget should identify both CRT staffing and the transport capacity required for simultaneous dispatch, and evaluation should confirm that ambulance coverage is maintained.

The pilot should define clinical inclusion criteria, staffing, geographic coverage, dispatch protocols and the required relationship between CRT and transport-ambulance resources.

Evaluation should include time to critical clinical intervention, CRT arrival, paired ambulance arrival, time to transport when appropriate and patient outcomes, using appropriate risk adjustment, comparison areas and pre/post analysis before considering expansion. Risk adjustment accounts for differences in patient severity, underlying conditions and other relevant clinical circumstances so that comparisons do not mistake changes in the patients served for changes in performance.

Bring the Pieces Together: An EMS Improvement and Modernization Task Force

The preceding recommendations share one important characteristic:

No single City agency or participating organization controls all of the factors necessary to carry them out.

FDNY operates the EMS system, but it does not independently control all of the factors that determine how that system performs.

Hospital turnaround requires cooperation among FDNY, Health + Hospitals, GNYHA and receiving hospitals. Workforce issues involve OLR, EMS labor and budget decisions. Capacity decisions require OMB, while recruitment, civil service processes and fleet support require participation by DCAS. Communications, technology, predictive deployment and performance measurement involve still other responsibilities of City agencies and participating organizations.

A systemwide problem requires a systemwide management response.

I therefore recommend that the Mayor establish an EMS Improvement and Modernization Task Force, including at minimum:

FDNY;

the Office of Management and Budget;
the Office of Labor Relations;
the Department of Citywide Administrative Services (DCAS);
NYC Health + Hospitals;
the Greater New York Hospital Association;
EMS labor; and
other appropriate City agencies and stakeholders.

The City agencies and participating organizations represented on the Task Force already collectively possess much of the data, operational expertise, decision-making authority and control over resources necessary to improve the system.

The Comptroller's findings should serve as a starting point for the Task Force's work, not as a substitute for it. The Task Force should reconcile the City's differing performance measures, connect workforce and fleet-readiness data to actual staffed and dispatchable ambulance-hours, and test which changes in staffing, deployment, dispatch and hospital turnaround would most reliably improve patient access to care.

Bringing them together would allow the City to establish a common factual picture of EMS performance, determine where capacity is being lost and delays are occurring, evaluate alternative solutions, assign implementation responsibility, and measure both operational performance and, where appropriate, clinical outcomes.

The Council should maintain active oversight

, supported by regular public reporting.

The pending-dispatch condition identified in Introduction 990-2026 should be among the operational indicators examined in that oversight, regardless of the Council's ultimate disposition of the bill.

The Task Force should not become another study committee. Its purpose should be implementation.

Establish a Timetable for Action

The effort should proceed on a defined timetable.

Within 30 days: Convene the Task Force with accountable senior representatives, establish data-sharing arrangements and agree upon the principal clinical and operational performance measures.

Within 60 days: Complete an initial system assessment covering workforce, staffed and available capacity, deployment, emergency communications, hospital turnaround and geographic reliability, and identify actions that can be taken immediately under existing authority and resources.

The initial assessment should explicitly address the Comptroller's October 16 findings and identify which conclusions are supported by existing data, which require further verification, and which operational

interventions can be evaluated promptly. This would turn an independent diagnosis into a measurable implementation agenda.

Within 90 days: Submit an initial EMS Improvement and Modernization Implementation Plan to the Mayor and Council identifying performance targets, resource requirements, responsible City agencies and participating organizations, immediate actions and longer-term initiatives.

Within six months: Begin priority operational improvements and pilots, including enhanced predictive deployment and, if supported by the analysis, a CRT/CRV pilot with simultaneous transport-ambulance dispatch.

Within 12 months: Report comprehensive results against the established performance standards, including the percentage of calls meeting the applicable thresholds citywide, by borough and, where statistically reliable, by community board.

Thereafter, performance should be reported publicly on a regular basis.

Measure Results and Maintain Accountability

Success should not be measured simply by the number of new units announced, programs created or dollars spent.

The ultimate question is whether patients receive appropriate care more quickly and more reliably.

Over time, the City's performance framework should also move beyond operational measures alone and increasingly connect EMS performance to clinical outcomes.

Response time is important, particularly for time-sensitive conditions, but it is only one factor affecting what ultimately happens to the patient. Outcomes may also reflect the patient's underlying condition, the interval before 911 is called, bystander intervention, the appropriateness of treatment protocols, responder training and skill, the timeliness of critical interventions, and subsequent hospital care.

The City should therefore develop clinically appropriate outcome measures for selected conditions where a meaningful relationship between EMS intervention and patient outcome can be evaluated.

Cardiac arrest provides an appropriate starting point because FDNY already reports clinical outcomes for cardiac-arrest patients.

The objective should be to connect system resources and operational performance to the timeliness and quality of clinical intervention and, ultimately, to patient outcomes, using appropriate risk adjustment so that differences in patient populations and clinical circumstances are taken into account.

The progression in performance measurement should increasingly connect:

System resources → Operational performance → Clinical intervention → Patient outcome

Public reporting should allow the Council, Administration, workforce and public to determine:

Are more patients being reached within clinically appropriate response standards?

Are geographic disparities in service reliability narrowing?

Are extremely long responses becoming less frequent?

Are more scheduled ambulance-hours actually staffed and available?

Are patient-transfer delays decreasing?

Are recruitment and retention improving?

For ultra-time-critical conditions, including cardiac arrest, is the time to meaningful clinical intervention improving?

Where appropriate and measurable, are improvements in EMS performance associated with improved clinical outcomes?

Those are the measures that connect operational changes and public resources to results experienced by patients.

Conclusion

Almost 40 years after I left New York City EMS, many of the underlying management challenges remain familiar. What has changed dramatically are the tools available to address them.

The City today possesses data, communications capabilities, predictive analytics and operational technology that were unimaginable when I managed EMS. The City agencies and participating organizations that would participate in an EMS Improvement and Modernization Task Force collectively possess the expertise, information, authority and resources necessary to turn those capabilities into action.

New York has an opportunity to combine a stable EMS workforce, sufficient and reliably available capacity, resilient emergency communications, improved hospital turnaround, more effective deployment and clearly defined clinical and operational performance standards into a coordinated strategy.

Response time is the symptom. The challenge before us is to understand and improve the entire system that produces it—from the 911 call to the delivery of appropriate patient care.

And ultimately, the objective should extend beyond improving a response-time statistic. It should be to ensure that the right clinical resources reach patients quickly enough to provide effective care and, where measurable, improve patient outcomes.

I respectfully recommend that the Council use its oversight role to help define the performance New Yorkers should expect, encourage the Mayor to establish an EMS Improvement and Modernization Task Force, and require transparent reporting of progress and results.

The objective is straightforward:

Define the performance New Yorkers should expect; use the City's data to determine why those expectations are not consistently being met; identify what is required to achieve them reliably; and provide the coordinated leadership, resources and accountability necessary to make it happen.

Thank you for the opportunity to testify.

James T. Kerr
Former Executive Director, New York City EMS
President, KERR Associates, Inc.

Appendix Supporting data and comparisons

These supporting figures provide historical context for the principal findings in the testimony. Monthly records, weekly records and annual measures cover different periods and must be interpreted using their respective definitions.

A1 Borough ambulance response and September ALS performance

Borough	June	August	Sept	Sept calls	ALS <10 min	ALS calls
Brooklyn	12:32	11:40	12:44	12621	28.30%	6038
Bronx	18:20	15:17	16:57	9881	19.45%	2514
Manhattan	15:14	13:56	15:33	10332	32.48%	4061
Queens	15:12	14:10	15:47	9123	18.78%	3930
Staten Island	11:43	12:47	13:26	2028	31.28%	908

June, August and September ambulance averages are minutes and seconds. ALS percentages and ALS incident counts refer to September and use a separate denominator.

A2 Response clocks

The combined FDNY dispatch-to-arrival time for ambulances and fire companies responding to life-threatening medical emergencies increased from 7 minutes 45 seconds to 9 minutes 13 seconds.

By contrast, when response time is measured from the initial 911 call to arrival at the scene, the combined ambulance/fire response averaged 11 minutes 55 seconds, while the ambulance response alone averaged 13 minutes 9 seconds.

A3 Weekly performance

Newly available weekly City data show that the problem continued into August 2026. For the week beginning August 17, the City recorded 10,109 life-threatening EMS incidents, with an average end-to-end ambulance response of 13 minutes 4 seconds. For the week beginning August 24, there were 8,581 life-threatening incidents and the average end-to-end response was 12 minutes 33 seconds. Non-life-threatening emergencies averaged 29 minutes 33 seconds and 25 minutes 15 seconds, respectively, during those two weeks.

The August data also reinforce the importance of examining the entire response continuum rather than ambulance travel time alone. During the week beginning August 24, average EMS travel time for life-threatening incidents was approximately 8 minutes 23 seconds, compared with 12 minutes 33 seconds from the initial 911 call to ambulance arrival. The difference occurred elsewhere in the end-to-end process and supports separate measurement of call processing, dispatch, unit assignment, turnout and travel, as well as staffed ambulance availability.

A4 Response distribution

The August weekly data illustrate why distribution measures matter. For the week beginning August 24, the average end-to-end response to life-threatening incidents was 12 minutes 33 seconds, while the median was

approximately 9 minutes 15 seconds. That gap indicates that averages alone do not describe the full range of patient experience and strengthens the case for reporting the median, 75th percentile and 95th percentile, together with the percentage of calls meeting clinically appropriate response standards.

A5 August ALS borough comparison

For comparison, the August 2026 ALS borough breakdown was: Bronx, 21.91% of 2,592 measured ALS incidents; Queens, 21.44% of 3,998; Brooklyn, 32.45% of 6,185; Manhattan, 36.03% of 4,155; and Staten Island, 30.68% of 955. These percentages use the same defined ALS measure as the September figures, not all life-threatening emergencies.¹³

A6 Fleet readiness

The City's Fleet Daily Service Report for August 26, 2026 showed 633 ambulances in the FDNY fleet, a target of 332 ambulances in service, and 446 reported as actually in service from a vehicle-readiness standpoint. The FY2027 year-to-date average through that date was 441.

However, the City's "Actual in Service" fleet measure identifies vehicles that are available and not out of service for repair. It does not establish how many of those ambulances were fully staffed with EMTs or paramedics, placed into 911 service, or actually available to accept an emergency assignment.

A7 Recruitment and net capacity

FDNY is taking steps to strengthen the workforce. On August 13, 2026, the Department graduated 124 probationary EMTs and promoted 58 EMTs to paramedic. These are important additions and upgrades to the EMS workforce, but the relevant capacity measure is the net effect on staffed and available ambulance-hours after attrition, vacancies and other workforce losses are taken into account.

The City should therefore determine how many additional staffed ambulance-hours resulted from the August graduating class and what the net change in EMS staffing was after separations and internal movement. That would connect recruitment and promotion activity directly to operational capacity and service reliability.

A8 Weighted calculations

September weighted calculations use 43,985 life-threatening incidents and 17,451 ALS incidents across the five boroughs, excluding Unspecified records. The weighted ALS estimate is 26.01%, compared with 29.20% in August and 26.89% in June. Values are calculated from published counts and rounded borough values.¹⁴

¹³ NYC Open Data, Local Law 119 Category 9 records for June, August and September 2026; retrieved October 12, 2026. <https://data.cityofnewyork.us/Public-Safety/911-Open-Data-Local-Law-119/gpny-cuvw>

¹⁴ NYC Open Data Local Law 119, CSV retrieved October 12, 2026. <https://data.cityofnewyork.us/Public-Safety/911-Open-Data-Local-Law-119/gpny-cuvw>