Policy Brief

for

Amplifying Florida EMS Voices

Results of the 2026 Annual EMS Agency Survey

Florida Center for Emergency Medical Services
Morsani College of Medicine
University of South Florida
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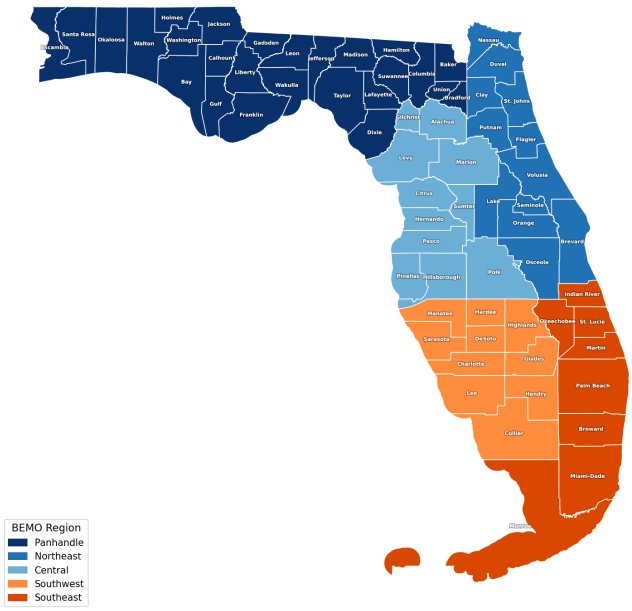
POLICY BRIEF

Florida Center for Emergency Medical Services

Amplifying Florida EMS Voices

Results of the 2026 Annual EMS Agency Survey

A statewide view of agency operations, workforce capacity, system readiness, and community integration - translated into practical implications for policy and planning.



AT A GLANCE

69.5% response rate among eligible in-state ground agencies

60.3% agencies reporting an active staffing shortage

58.5% agencies reporting a paramedic shortage

About This Policy Brief

This policy brief distills the major findings and policy implications from Amplifying Florida EMS Voices: Results of the 2026 Annual EMS Agency Survey. The full report provides a comprehensive analysis of Florida EMS agency operations across workforce development, medical care, health and wellness, access to care, public engagement, data and quality improvement, telecommunications, disaster preparedness, pediatric care, and trauma. This condensed brief is intended for policymakers, state and regional planners, EMS leaders, and other decision-makers who need actionable findings without the full technical detail of the underlying report.

The 2026 Annual Florida EMS Agency Survey was conducted by the Florida Center for Emergency Medical Services at the University of South Florida on behalf of the Florida Department of Health Bureau of Emergency Medical Oversight. The survey was open from February 26 through May 5, 2026. Of 308 in-state ground EMS agencies eligible when the survey opened, 214 submitted usable responses, yielding a 69.5% response rate. The final analytic dataset included 230 agencies, including agencies licensed during the field period and a small number of out-of-state agencies operating in Florida.

The purpose of the survey is not simply to inventory agency capabilities. By examining agency size, organizational type, region, and rural status together, the report identifies the structural factors that help explain why particular programs and capabilities develop in some parts of Florida's EMS system but not others. These findings provide an evidence base for statewide resource planning and development of Florida's EMS State Plan.

HOW TO READ THIS BRIEF

Four structural lenses

Throughout the report, findings were tested against agency size (call-volume cohort), fire versus non-fire organization, BEMO region, and rural designation. These factors are not interchangeable proxies for quality. Each describes a different axis of the EMS system.

Survey at a Glance

214 of 308	69.5%	230	11
eligible in-state ground agencies submitted usable responses	response rate	agencies in the analytic sample	thematic survey modules

The 2026 survey used a modular design that allowed agencies to assign sections to subject-matter experts. Response rates improved on many retained items compared with the prior survey cycle, while module-level completion varied because not every agency answered every module.

Executive Summary

Florida's EMS system is highly diverse. Agencies range from small organizations handling fewer than 200 calls annually to major metropolitan systems responding to more than 300,000. Across this diversity, one finding recurs more consistently than any other: agency size is the strongest predictor of the infrastructure and organizational capacity an EMS agency has been able to build.

Larger agencies are more likely to maintain flexible staffing, invest more heavily in medical direction, offer broader behavioral-health support, participate in data-sharing systems and health care coalitions, operate mobile integrated healthcare or community paramedicine programs, designate pediatric emergency care coordinators, and adopt a variety of administrative and clinical capabilities. This does not mean that larger agencies provide uniformly better care. Several important practices - including hemorrhage-control protocols and infectious-disease preparedness - are broadly distributed regardless of size. Trauma care is similarly notable for relatively little structural variation. Rather, agency size appears to determine the breadth of infrastructure an organization can sustain beyond these widely adopted baseline practices.

Workforce capacity remains the clearest system-wide pressure point, and the shortage is concentrated in paramedics. Among agencies answering the workforce shortage question, 60.3% reported an active shortage of EMTs, paramedics, or both. A paramedic shortage was reported by 58.5%, compared with 21.4% reporting an EMT shortage. The pattern suggests that Florida does not face a generalized EMS staffing problem so much as a specific constraint in the paramedic pipeline.

60.3%	58.5%	21.4%
report any active staffing shortage	report a paramedic shortage	report an EMT shortage

A second major finding concerns organizational model. Fire-based and non-fire EMS agencies appear to develop different kinds of strengths. Fire-based systems more often lead in functions tied to tactical operations, dispatch integration, behavioral-health program breadth, salary, and workforce stability. Non-fire agencies more often report structured customer feedback, health information exchange participation, performance-linked incentives, medication-assisted treatment for substance use disorder, and use of tranexamic acid. These differences remain after accounting for agency size and location and should not be interpreted as evidence that one organizational model is superior to another.

Rural status is a more focused disadvantage than it initially appears. Many apparent rural differences disappear after accounting for the fact that rural agencies tend to be smaller and are more often non-fire organizations. Two important gaps remain: access to local mental-health providers trained for first responders and dispatch-level stroke screening. Both depend partly on resources outside the EMS agency itself, making them ecosystem-level access problems rather than shortcomings that an individual rural agency can solve simply by increasing internal capacity.

BOTTOM LINE

Targeted policy beats uniform policy

The strongest opportunities for statewide action are not one-size-fits-all. Workforce strategy should focus on the paramedic pipeline; infrastructure support should recognize the fixed costs faced by smaller agencies; rural policy should target ecosystem access; and community programs should be tied explicitly to measured local need.

Florida EMS in 2026: A System Shaped by Scale

The central structural finding of the 2026 survey is the importance of agency size. Florida EMS agencies differ enormously in annual call volume, staffing, organizational form, geography, and available resources. The report grouped agencies into five call-volume cohorts and tested agency size alongside fire versus non-fire status, BEMO region, and rural designation throughout the analysis.

Across domains, call volume repeatedly emerges as the strongest predictor of organizational breadth. Larger agencies are better positioned to maintain staffing flexibility, support more extensive behavioral-health resources, participate in health information exchange, engage in regional preparedness structures, operate MIH/CP programs, and establish dedicated roles such as Pediatric Emergency Care Coordinators. Smaller agencies appear less able to sustain these infrastructure-intensive functions even when fundamental clinical practices are in place.

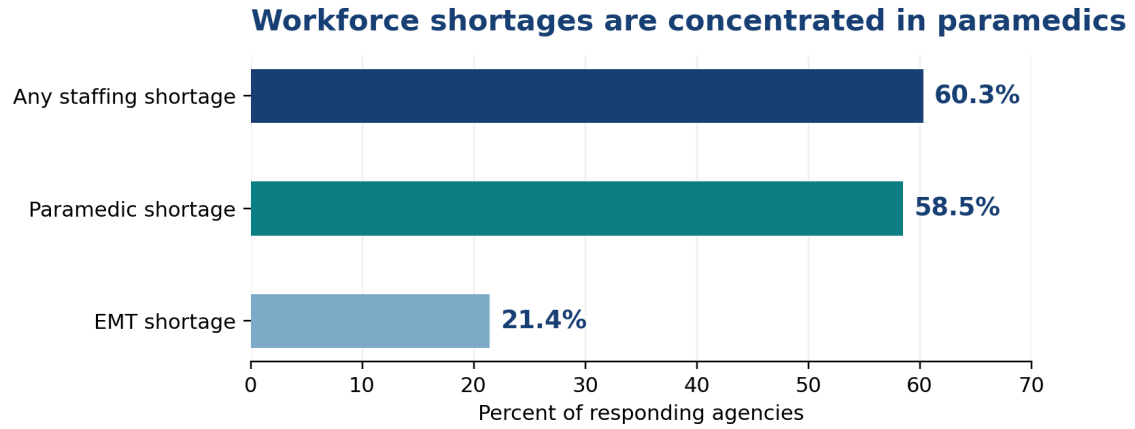
POLICY INTERPRETATION

Scale is not the same as quality

A capability gap associated primarily with agency size is different from a gap caused by poor clinical practice. The former often reflects fixed costs of participation, staffing, technology, administration, or coordination. Shared services and regional infrastructure may therefore be more efficient than expecting every small agency to independently build metropolitan-scale capability.

Workforce: The Paramedic Pipeline Is the Pressure Point

Workforce shortages are widespread, but they are not evenly distributed across certification levels. Of 229 responding agencies, 60.3% reported an active staffing shortage. Nearly six in ten agencies reported a paramedic shortage, while only about one in five reported an EMT shortage. Shortages limited exclusively to EMTs were rare.



Source: 2026 Florida EMS Agency Survey. Workforce shortage item responding n = 229.

The salary findings reinforce a recruitment-focused interpretation. Agencies offering higher starting pay report meaningfully fewer vacancies, while higher salaries later in an employee's career do not demonstrate the same relationship. Agencies with a greater number of retention initiatives likewise do not consistently report lower vacancy levels. These associations cannot establish causation, but they suggest that entry-level competitiveness and successful recruitment may be especially important leverage points.

Organizational type also matters. Fire-based systems report markedly lower turnover than non-fire systems, while private EMS organizations report the highest turnover. The workforce findings argue for a more targeted approach: strengthen the paramedic training and recruitment pipeline, examine barriers to EMT-to-paramedic progression, evaluate entry-level compensation, and differentiate strategies for organizations that do not have the employment structures available to municipal fire departments.

Different Agency Models Build Different Strengths

Fire departments are the dominant organizational model in Florida EMS, but the survey shows that organizational type influences capabilities in ways that cannot be reduced to a simple advantage or disadvantage. Fire-based agencies lead most clearly when a function depends on integrated public-safety infrastructure. Non-fire agencies lead in a separate group of practices that may reward external benchmarking, contractual accountability, data interoperability, or rapid protocol modification.

FIRE-BASED AGENCIES MORE OFTEN LEAD IN	NON-FIRE AGENCIES MORE OFTEN LEAD IN
• Tactical and active-assailant readiness • Dispatch-linked CPR and stroke screening • Lower workforce turnover • Higher base salary • Broader behavioral-health support • Pediatric community risk-reduction activity	• Structured customer-satisfaction feedback • Health information exchange participation • Performance-linked incentives • Medication-assisted treatment for substance use disorder • TXA adoption • Selected data and accountability practices

The survey cannot determine why these differences occur, and the explanation should remain cautious. Fire departments benefit from integration with dispatch, tactical response, municipal infrastructure, and stable public-sector employment systems. Non-fire organizations may operate in environments that place greater emphasis on external benchmarking, customer feedback, contractual performance, data exchange, and protocol turnover. These are plausible mechanisms, not causal findings.

POLICY IMPLICATION

Learn across models

Florida's EMS system contains multiple organizational models that appear to have developed different areas of strength. Statewide improvement efforts should identify successful practices across organizational types and facilitate their transfer rather than treating one model as the universal template for EMS system development.

Behavioral Health Support Also Scales with Size

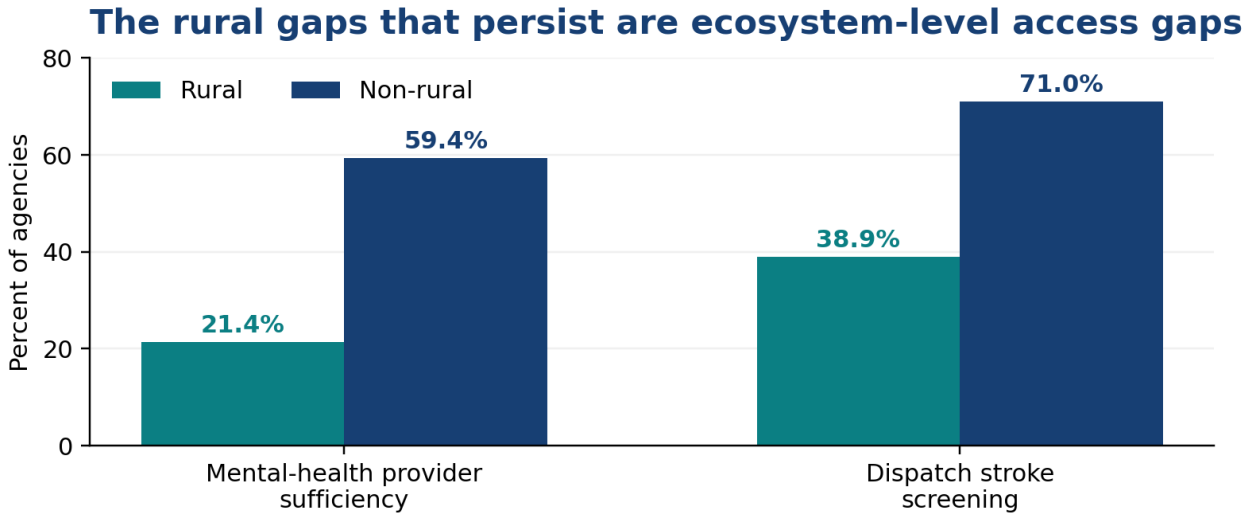
Behavioral-health programs illustrate how agency size and organizational type can operate independently. Larger agencies offer substantially broader support, and fire-based agencies provide more components than non-fire agencies within the same size cohort. A large non-fire agency may still offer more than a small fire agency, underscoring that neither factor substitutes for the other.

1.5 to 6	5 vs. 3	$p < 0.001$
median support components from the smallest to largest call-volume cohorts	median components in fire vs. non-fire agencies overall	independent effects of both agency size and fire status

Rural EMS: A Focused Ecosystem Access Problem

Rural EMS agencies often appear disadvantaged when examined in isolation. The 2026 analysis, however, shows that many of these differences are explained by agency composition. Rural agencies tend to be smaller and more often operate outside the fire-service model. Once agency size and organizational type are taken into account, many apparent rural disparities diminish substantially.

The differences that remain are therefore especially important. The clearest is access to behavioral-health expertise. Statewide, 52.4% of agencies report that sufficient local mental-health providers are available and trained to work with first responders. Among rural agencies, however, only 21.4% report sufficient access, compared with 59.4% of non-rural agencies. Rural status remains the significant predictor after adjustment for agency size, organization type, and region.



Rural disparities that persist after adjustment involve resources outside the individual EMS agency. Source: 2026 Florida EMS Agency Survey.

A second persistent rural gap occurs in dispatch stroke screening: 38.9% of rural agencies report this capability compared with 71.0% of non-rural agencies. The disparity remains after adjustment and is independent of the separate fire-status effect observed in dispatch capabilities.

These findings describe a different type of policy problem than the scale-related gaps identified elsewhere in the report. A small agency may potentially improve an internal protocol, purchase equipment, or participate in shared training. It cannot by itself create a regional behavioral-health workforce or fully restructure an external dispatch center. The most persistent rural disadvantages therefore occur where EMS depends on capabilities located in the surrounding health and public-safety ecosystem.

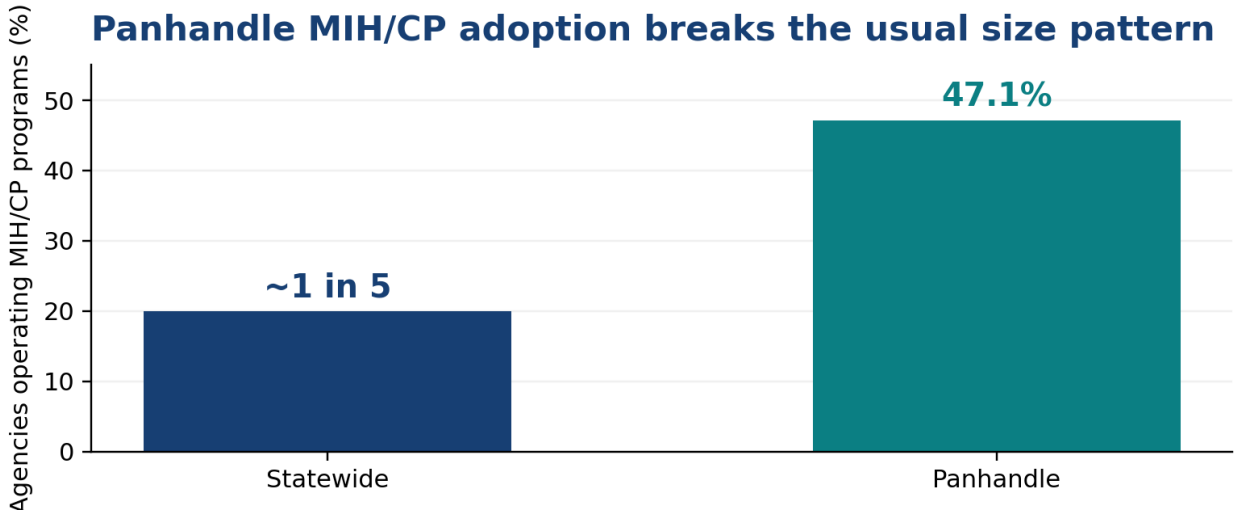
PLANNING IMPLICATION

Target the ecosystem, not just the agency

Regional behavioral-health networks, tele-behavioral health, specialized first-responder referral resources, and stronger emergency medical dispatch infrastructure may address the remaining rural gaps more directly than general-purpose agency funding alone.

Community Health: Programs Do Not Always Follow Need

Approximately one in five agencies operate a mobile integrated healthcare or community paramedicine program, and statewide adoption rises sharply with agency size. The Panhandle is the major exception. Despite having the smallest average agencies among Florida's regions, 47.1% of Panhandle agencies report MIH/CP programs, the highest regional adoption rate in the state. This difference remains significant after adjustment for agency size, fire status, and rural designation.



Statewide MIH/CP adoption is about one in five agencies; Panhandle adoption is 47.1%.

The regional pattern appears to be linked in part to the opioid epidemic and to funding mechanisms developed in response. Panhandle MIH programs rely disproportionately on opioid settlement dollars, and naloxone leave-behind programs are three to five times more common in the Panhandle and Central Florida than in the Southeast or Northeast. In this domain, EMS programming appears to have followed community burden relatively closely.

Infant-mortality reduction programs provide an instructive counterexample. Only about one in five agencies participates in such a program, and program participation shows no meaningful relationship with county infant mortality rates. The correlation between county-level infant mortality and agency program participation was essentially zero (Spearman rho = 0.017, p = 0.81). Even the Panhandle, which carries the state's highest median regional infant mortality rate, was not disproportionately represented after agency size was taken into account.

OPIOID RESPONSE: NEED-ALIGNED

MIH/CP and naloxone leave-behind programs cluster in regions with elevated opioid burden. Opioid settlement funding created a visible mechanism connecting burden to program resources.

INFANT MORTALITY: NOT NEED-ALIGNED

Program participation varies geographically but does not track county infant-mortality burden. Existing program geography appears to reflect institutional history and partnerships more than epidemiologic need.

The comparison has an important planning implication: a map showing where programs exist is not necessarily a map of where programs are needed. Future EMS community-health investments should incorporate explicit measures of local burden into program planning, funding decisions, and evaluation rather than assuming that existing geographic patterns represent appropriate targeting.

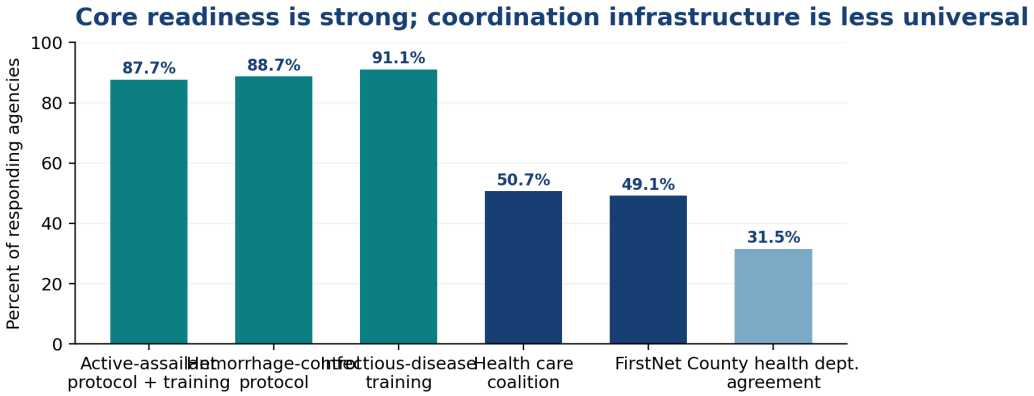
FUNDING HORIZON

Plan now for sustainability

Programs built substantially on opioid settlement funding will eventually need a different financial footing. The report notes that settlement funds are finite and projected to be exhausted around 2039-2040.

System Infrastructure, Preparedness, Pediatrics, and Trauma

Florida's EMS system demonstrates strong adoption of several core readiness practices. Active-assailant protocols with training are reported by 87.7% of responding agencies, hemorrhage-control protocols by 88.7%, and infectious-disease training by 91.1%. Infectious-disease preparedness is particularly uniform across agency size, organizational type, region, and rural status, suggesting that some capabilities have become system-wide baseline expectations.

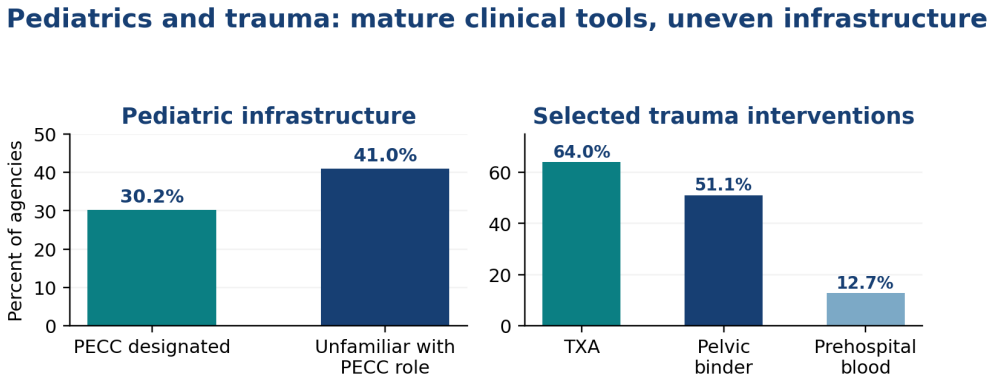


Preparedness and coordination capabilities. Denominators vary by item; source: 2026 Florida EMS Agency Survey.

The weaker areas involve coordination and shared infrastructure. Only 50.7% of responding agencies participate in a health care coalition, 49.1% use FirstNet for voice and data, and 31.5% report a written disaster agreement with a county health department. Coalition and FirstNet participation rise sharply with agency size, again highlighting the difficulty smaller agencies face in maintaining infrastructure-intensive relationships and systems.

Pediatrics and Trauma

Pediatric readiness is strongest in equipment and standardized clinical tools but weaker in organizational infrastructure. Only 30.2% of agencies report a designated Pediatric Emergency Care Coordinator (PECC), while approximately 41% report being unfamiliar with the role - suggesting that part of the gap reflects awareness and implementation rather than an unavoidable resource barrier.



Selected pediatric infrastructure and trauma intervention measures. Source: 2026 Florida EMS Agency Survey.

Trauma care presents a different pattern. Oxygen saturation monitoring is reported by 99.1% of agencies and end-tidal carbon dioxide monitoring by 96.5%. TXA is used by 64.0%, pelvic binders by 51.1%, and prehospital blood transfusion by 12.7%. Except for TXA, these practices vary little by agency size, organization type, geography, or rural status, suggesting that medical-director protocol decisions and the clinical evidence base matter more here than organizational capacity.

Policy Implications and Recommended Actions

1 Strengthen the paramedic pipeline

Florida workforce strategy should explicitly distinguish paramedic shortages from general EMS staffing shortages. Advanced-level workforce development should examine barriers to paramedic education, EMT-to-paramedic progression, training capacity, recruitment, and entry-level compensation. Higher starting salary is associated with fewer vacancies, making recruitment competitiveness an important policy lever.

2 Build shared infrastructure for smaller agencies

Because agency size predicts so many infrastructure-intensive capabilities, statewide planning should reduce the fixed cost of participation for smaller organizations. Shared technical assistance, regional data services, pooled behavioral-health resources, coalition support, interoperable technology, and common implementation resources may be more efficient than requiring each agency to build these functions independently.

3 Target rural ecosystem gaps

Rural EMS policy should focus on the disadvantages that remain after structural differences are taken into account: access to first-responder behavioral-health specialists and dispatch stroke-screening capability. These problems require solutions beyond the walls of the EMS agency, including regional partnerships, telehealth, and emergency medical dispatch infrastructure.

4 Align community programs with measured need

Florida's opioid-response experience demonstrates that community need, targeted funding, and EMS programming can align. Infant-mortality programming demonstrates that alignment should not be assumed. Future community-health programs should identify measurable burden, link resources to that burden, and evaluate whether program distribution changes as community need changes.

5 Spread strengths across organizational models

Fire-based and non-fire agencies demonstrate different areas of strength. Statewide initiatives should use this variation as a learning opportunity. Cross-model benchmarking can spread effective tactical and dispatch practices from fire-based systems and data, accountability, community-health, and selected clinical practices from non-fire systems.

6 Strengthen coordination, data feedback, and pediatric leadership

Health care coalition participation, FirstNet use, public-health agreements, data feedback, and PECC designation remain uneven. These are primarily integration and coordination functions rather than bedside clinical interventions. Clearer implementation pathways and targeted technical assistance may produce meaningful gains, especially where the barrier is awareness rather than staffing.

Conclusion

The 2026 Annual Florida EMS Agency Survey describes a system with significant strengths, but also one in which capability is distributed unevenly for identifiable reasons. Agency scale is the most consistent structural predictor of organizational infrastructure. Organizational type influences the kinds of capabilities agencies develop. Most apparent rural disadvantages diminish after these factors are considered, leaving a smaller number of genuine access gaps located largely outside the EMS agency itself. Regional variation, meanwhile, does not necessarily indicate that services are aligned with community need.

These distinctions matter for policy. A workforce recruitment problem requires a different intervention than a retention problem. A scale-related infrastructure gap requires a different solution than a clinical protocol gap. A rural ecosystem problem cannot necessarily be solved by funding an individual ambulance service. And a program concentrated in one part of the state cannot be assumed to be appropriately targeted until its distribution is compared with the burden it is intended to address.

STRATEGIC DIRECTION

Toward a better-connected system

Florida can use these findings to move from broad, uniform interventions toward more targeted system planning: strengthening the paramedic pipeline, sharing infrastructure with smaller agencies, addressing specific rural access gaps, aligning community programs with measured need, and spreading effective practices across organizational models.

Methodological Notes and Limitations

- The analytic unit is the EMS agency, not the individual clinician, patient, or community. A reported capability does not establish how consistently it is used within the agency.
- Most survey items are binary and identify whether a capability, program, or protocol exists; they do not measure implementation quality or fidelity.
- Call volume is used as a proxy for agency size, resource capacity, and organizational complexity. It is correlated with these constructs but does not directly measure them.
- The 69.5% response rate is adequate for descriptive analysis but does not eliminate the possibility of non-response bias. BLS-only and air agencies are under-represented relative to the ground ALS system.
- Adjusted analyses test agency size, fire status, BEMO region, and rural designation jointly. Associations should not be interpreted as causal effects.

Full Report

Lozano, M., Guadiana, C., & Klocksieben, F. (2026). Amplifying Florida EMS Voices: Results of the 2026 Annual EMS Agency Survey. Florida Center for Emergency Medical Services, USF Health Morsani College of Medicine, University of South Florida.

The full report contains detailed methodology, statistical analyses, tables, figures, chapter-specific limitations, and references. It remains the authoritative source for technical interpretation of the survey findings.

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