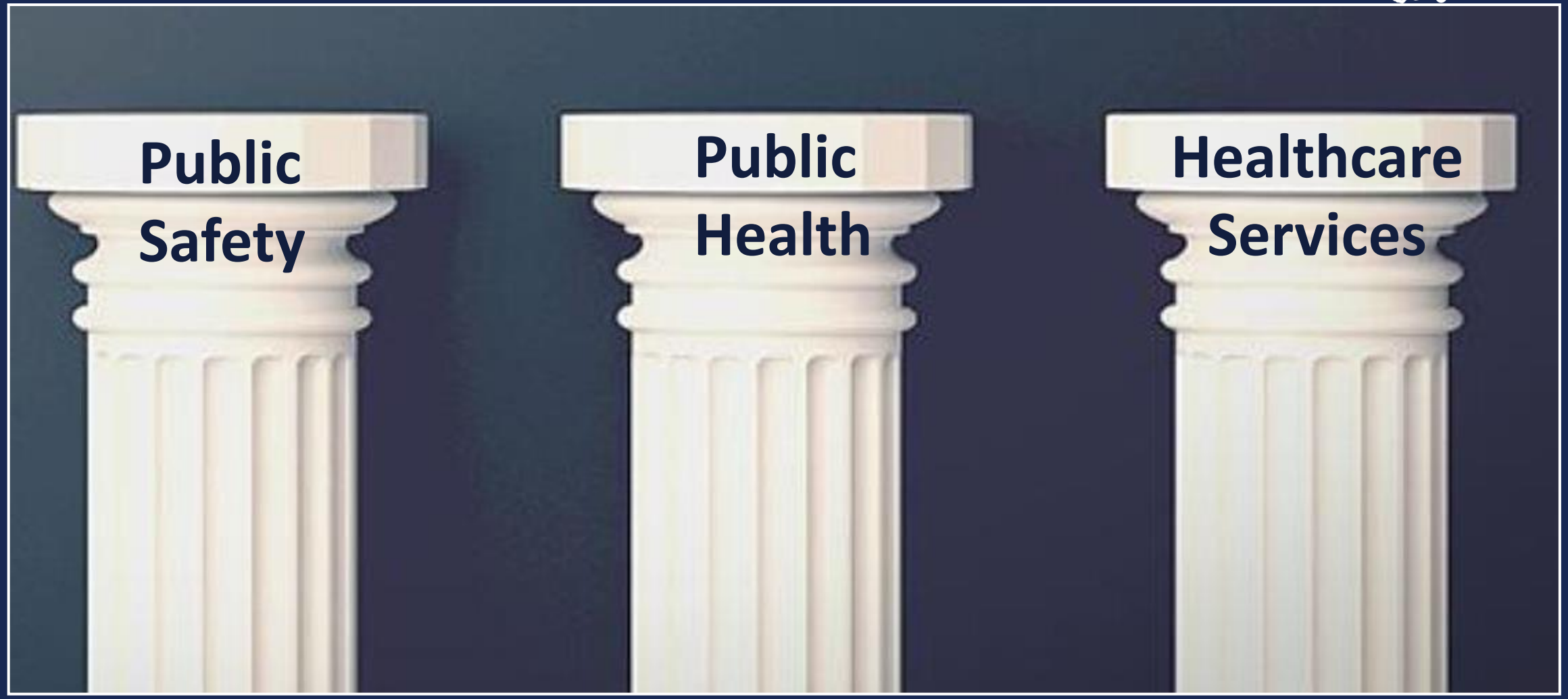
Indiana Rural Health Association
2021
EMS – Present and Future State

Tim Putnam, EMT, DHA
CEO, President
Margaret Mary Health

Michael A. Kaufmann, MD, FACEP, FAEMS
State EMS Medical Director
Indiana Department of Homeland Security

IDHS EMS Division



Objectives

- Welcome and introductions
- IDHS overview
- Current state of our EMS System in Indiana
- Challenges for our EMS System
  - Hospital Culture - Why You Should Care
  - No Port In A Storm – Diversion Issues
  - Rules, Regulation, Oversight – Why Hospital Transfers are Hard
  - EMS Reimbursement – An outdated paradigm
  - Workforce Worries – A declining workforce with no relief in sight
  - Future Direction and Opportunity – MIHCP

Meet Your Speakers

Tim Putnam, DHA, EMT

CEO, President

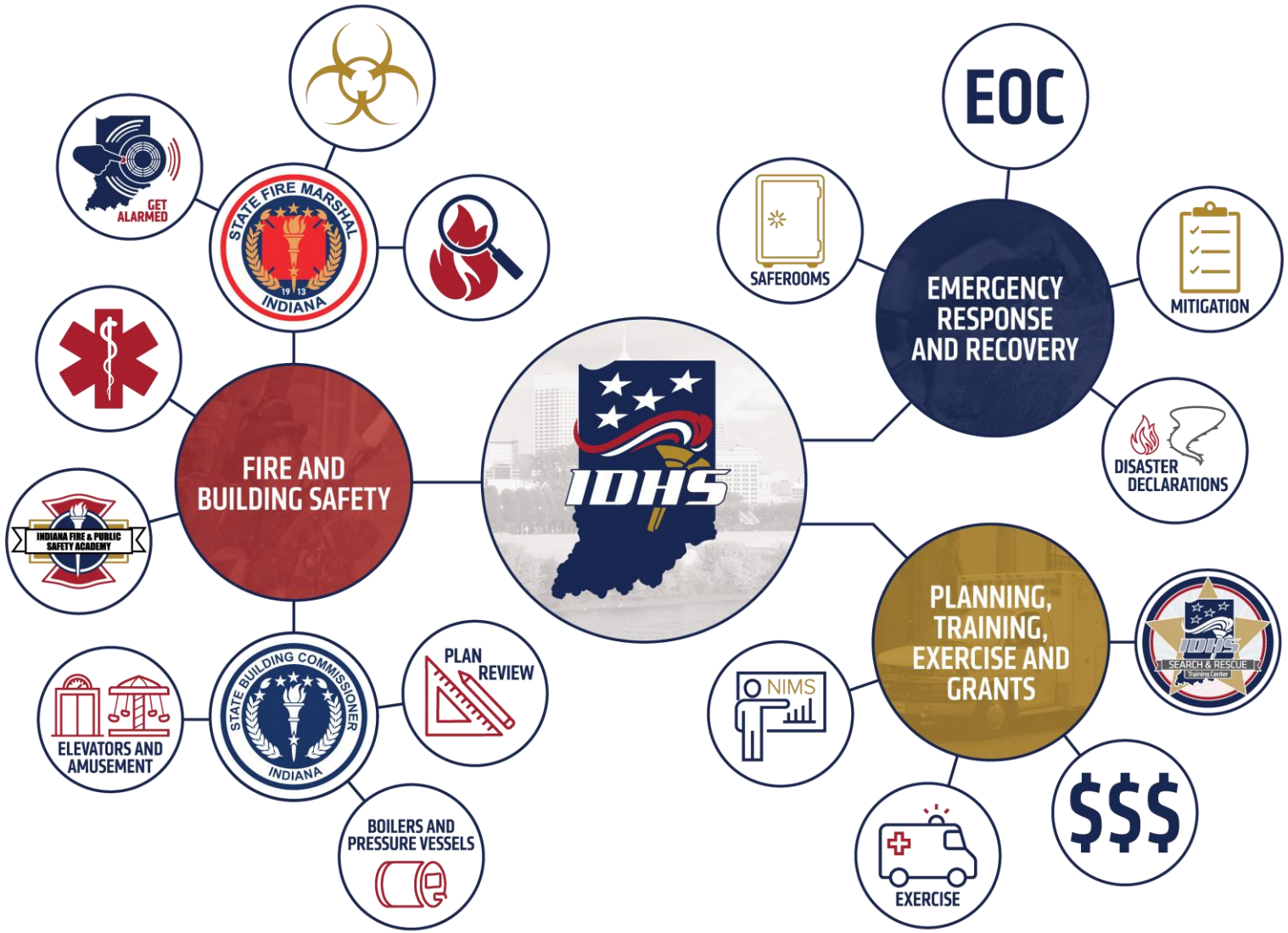
- Tim Putnam is President & CEO at Margaret and Mary Health located in Batesville, Indiana and has over 30 years of healthcare experience.
- He received his MBA from the University of Southern Indiana and Doctorate in Health Administration from the Medical University of South Carolina where his dissertation was focused on the treatment of acute stroke patients in community hospitals.
- He currently chairs of the National Rural Health Association's Policy Congress, Indiana Graduate Medical Education Board and the National Rural Accountable Care Consortium. In 2015 Dr. Putnam completed training as an Emergency Medical Technician and serves on the Batesville Fire and EMS Lifesquad

Michael A. Kaufmann, MD, FACEP, FAEMS

State EMS Medical Director

- Dr. Michael Kaufmann first became an EMT in 1992. He graduated from Indiana University in 1993 with a Bachelor of Science degree in microbiology.
- He graduated with his medical degree in 1997 and went on to complete an emergency medicine residency at the Case Western Reserve MetroHealth Medical Center Cleveland Clinic program in Cleveland, Ohio.
- Dr. Kaufmann has worked as an emergency physician at Ascension St. Vincent Hospital and Health Systems in and around central Indiana. He currently serves as the EMS Medical Director for local Ascension St. Vincent EMS affiliates
- Dr. Kaufmann is board certified in both Emergency Medicine and the sub-specialty of EMS.
- In early 2018 he was appointed the EMS Medical Director for the State of Indiana in the Department of Homeland Security.

IDHS


IDHS
FIRE AND BUILDING SAFETY
GET ALARMED
STATE FIRE MARSHAL
INDIANA
INDIANA FIRE & PUBLIC SAFETY ACADEMY
STATE BUILDING COMMISSIONER
INDIANA
PLAN REVIEW
ELEVATORS AND AMUSEMENT
BOILERS AND PRESSURE VESSELS
EMERGENCY RESPONSE AND RECOVERY
EOC
SAFEROOMS
MITIGATION
DISASTER DECLARATIONS
PLANNING, TRAINING, EXERCISE AND GRANTS
NIMS
IDHS SEARCH & RESCUE Training Center
$$$
EXERCISE

Emergency Medical Services Commission

Andrew Bowman	Emergency Nurses	Indianapolis	andrewj.bowman@gmail.com
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Dr. Sara Brown	Trauma Care	Fort Wayne	drsnoopy@ymail.com
Vacant	Emergency Physicians	Vacant	Vacant
Melanie "Jane" Cragin	Hospital Ambulance Service	Williamsport	mjcraigin@gmail.com
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Darin Hoggatt	Paramedics	Greenwood	hoggattd@greenwood.in.gov
Dr. Thomas Lardaro	Air Ambulance	Indianapolis	tlardaro@iu.edu
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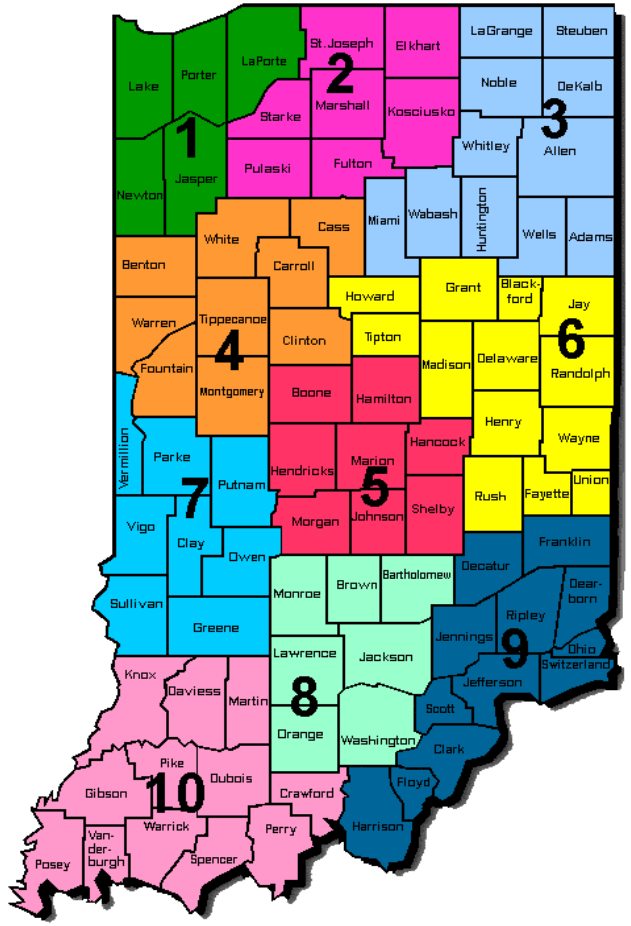
Charles Valentine	Municipal Fire Services	Indianapolis	cvalentine@decaturfire.org
John Zartman	ALS Training InstitutionProgram	Indianapolis	john.zartman@franciscanalliance.org

EMS CERTIFICATIONS

- Certificates — 2021, 2020, (2019)
  - Training Institutions — 115, 109, (115)
  - Supervising Hospitals — 82, 86, (91)
  - Providers — 837, 832,(833)
  - Vehicles
    - Ambulance — 1857, 2,249, (2,600)
    - ALS non-transport — 517, 476, (584)
    - Air Ambulance Rotorcraft — 59, 54, (52)
  - Personnel
    - EMR — 4816, 4870, 5055
    - EMT — 13733, 14006, 14448
    - Advanced EMT — 655, 642, 578
    - Paramedic (license) — 4696, 4518, 4408
    - Primary Instructor — 622, 611, 566

EMS System Metrics – as of January 2021

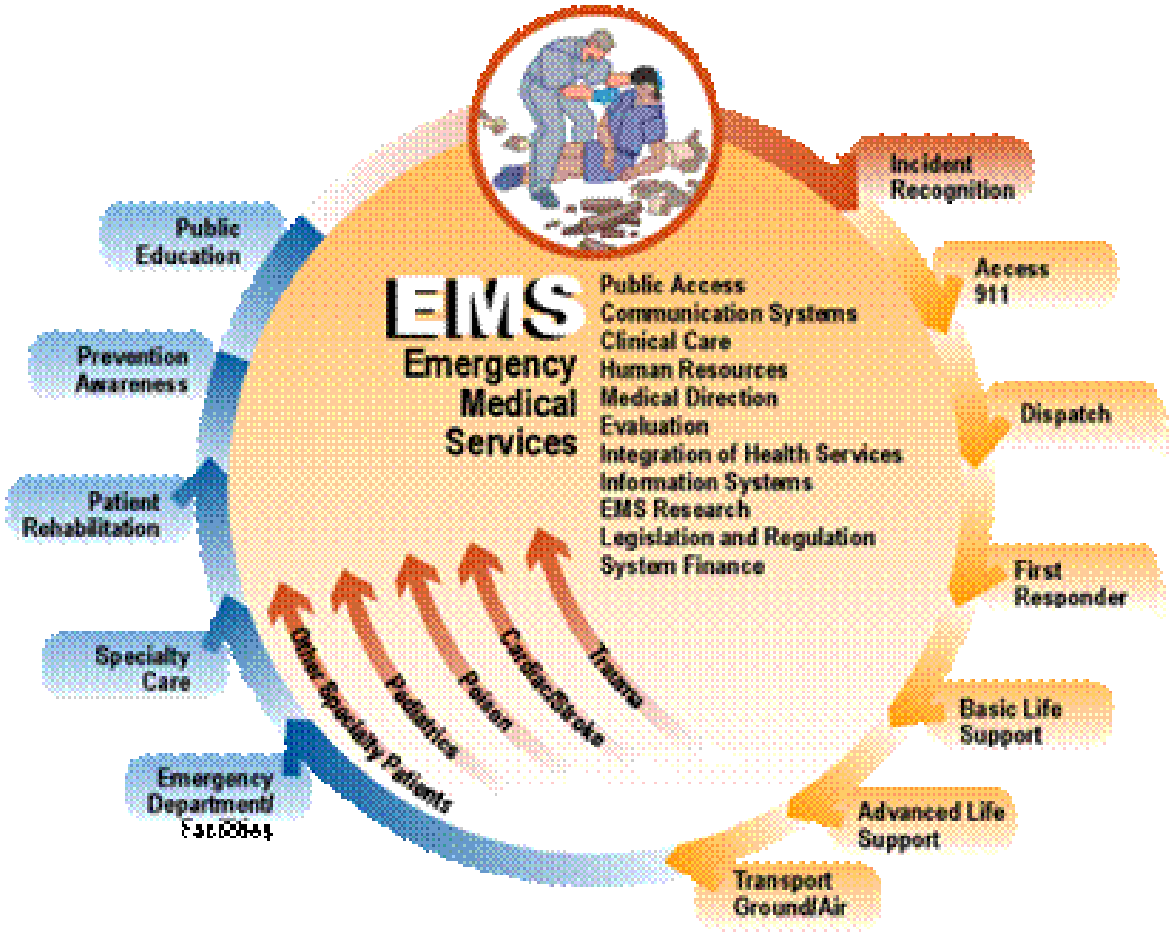
- Year 2021, (2020), (2019)
- Total Ambulances in state 1853, (1773) (2022)
- D1 – 274 (261) (363)
- D2 – 150 (148) (145)
- D3 – 117 (110) (111)
- D4 – 105 (100) (120)
- D5 – 450 (430) (492)
- D6 – 313 (292) (301)
- D7 – 72 (80) (84)
- D8 – 47 (47) (49)
- D9 – 211 (197) (245)
- D10 – 114 (108) (112)
- Total ALS non-transport vehicles 495 (476) (584)
- Total Rotocraft statewide 59 (54) (52)



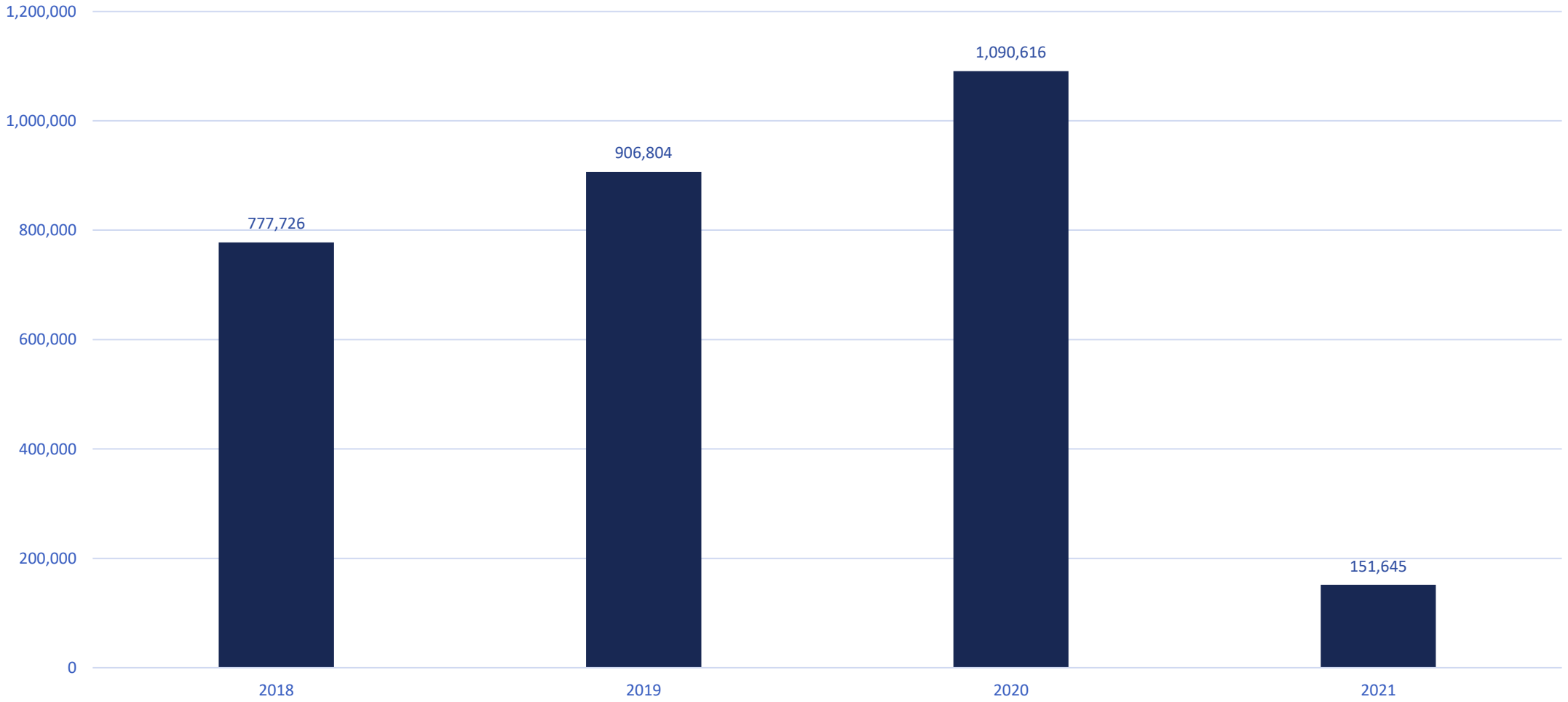
Indiana EMS Who's Who

- Private EMS – 56
- Hospital based – 41
- Governmental/Municipal EMS – 183
- Volunteer Ambulance - 46
- Volunteer Fire - 454 (most are BLS non-transport and DO NOT BILL for services)

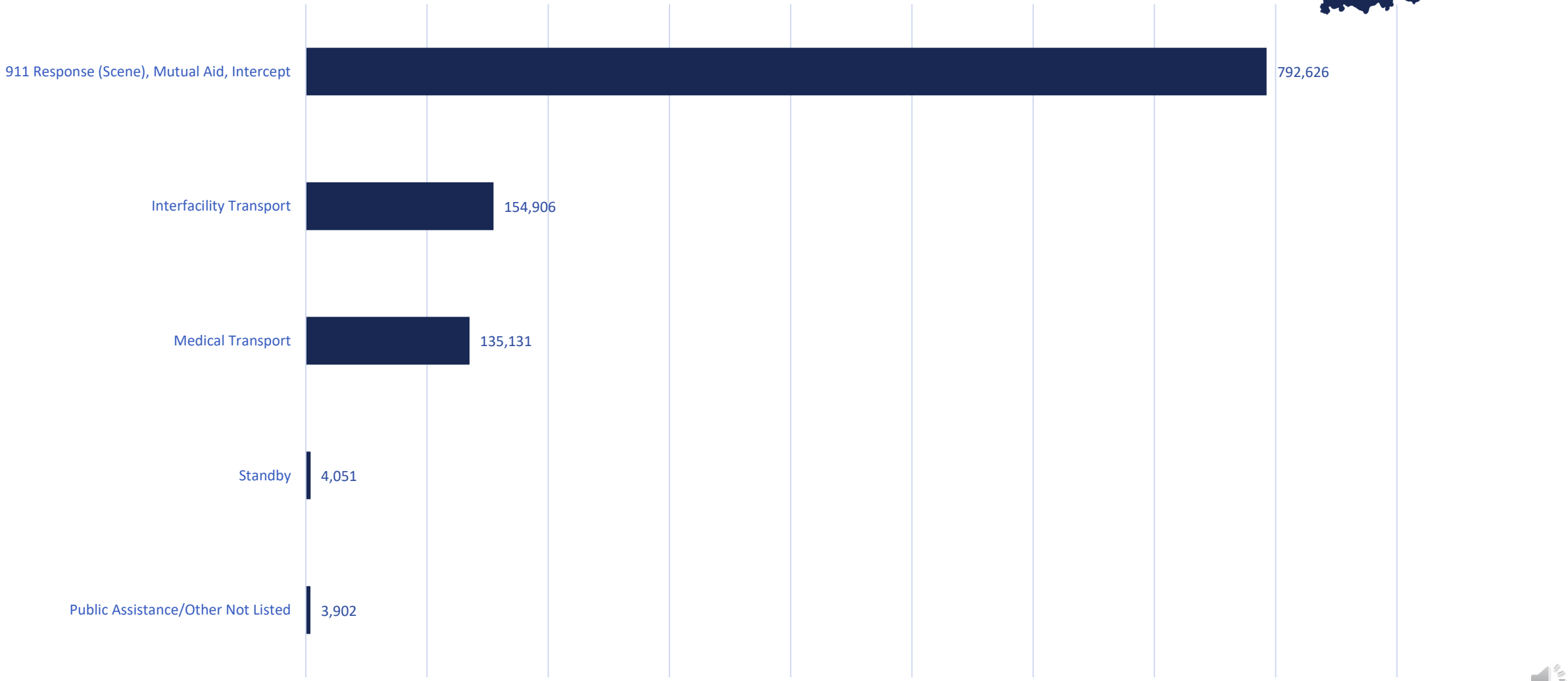
=70%



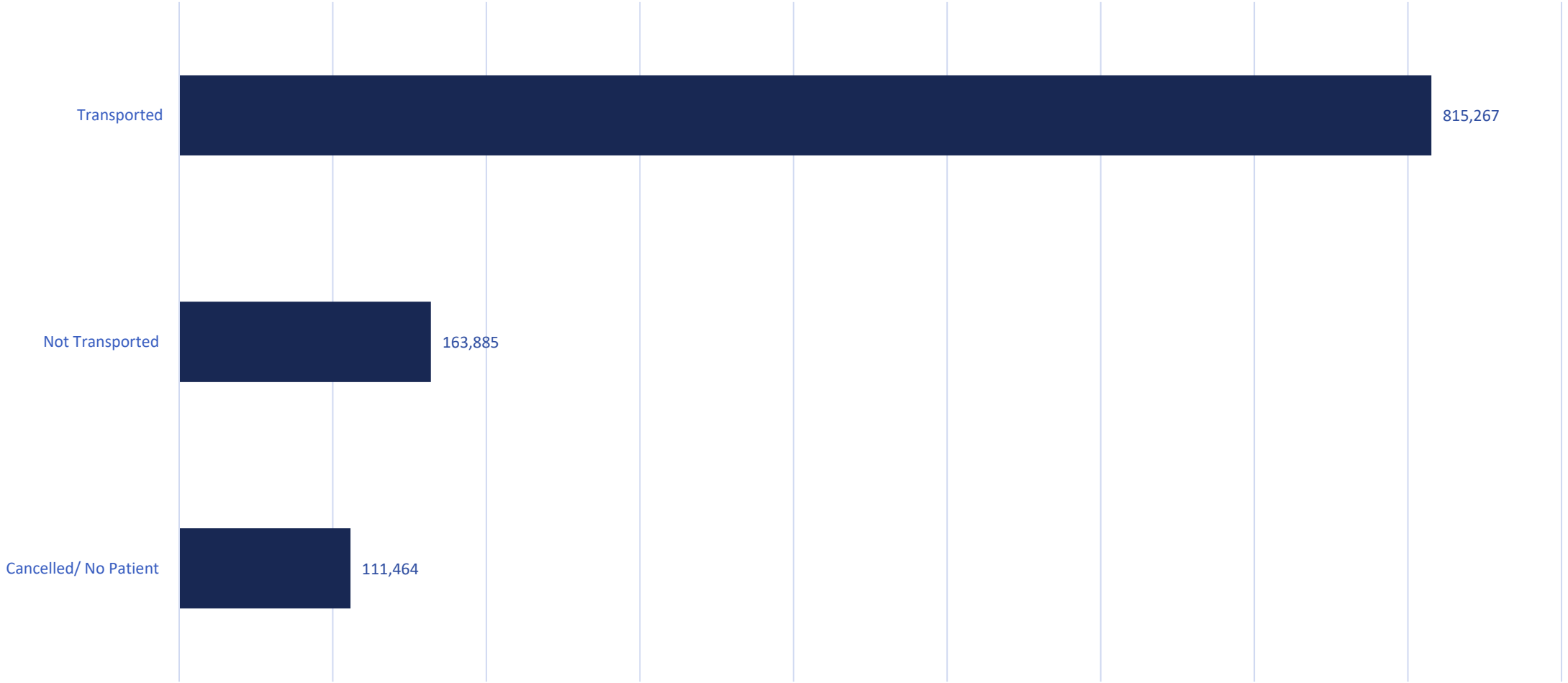
Annual Indiana EMS Run Volume - YOY



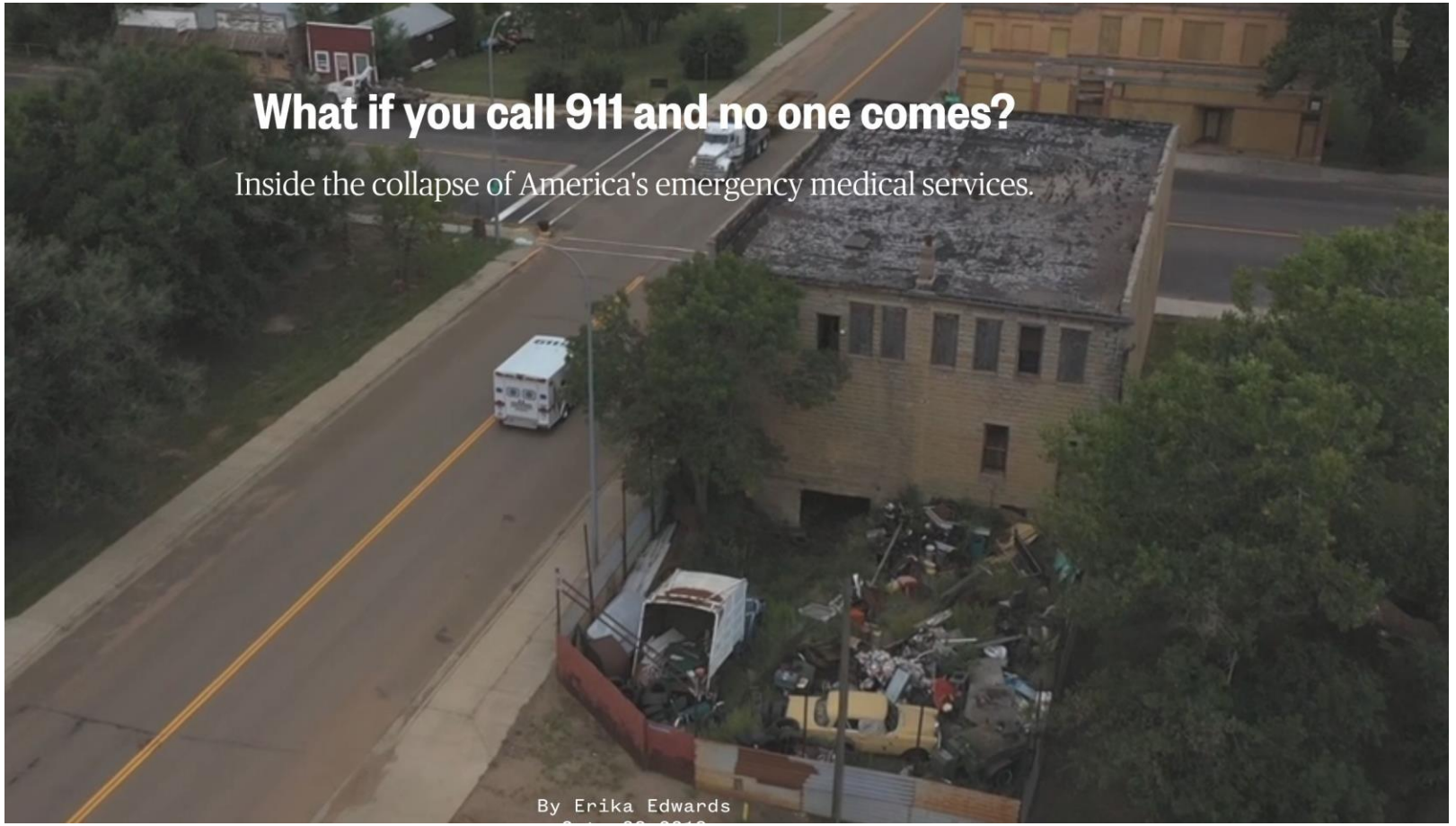
Type of Call - 2020



Disposition of Calls - 2020



Challenges Threatening the Indiana EMS System



Tim Putnam

Hospital Culture and EMS

Why you SHOULD care.

Why Hospitals Should Care About EMS

- Although it's not always recognized, EMS is one of a hospital's biggest clients and brings in a substantial amount of revenue,"
- Unless a patient specifically requests a certain facility, it is up to the EMS agency to pick the transport destination. Improving your relationship with your local EMS agencies should be viewed not as an expense but as an investment.
- What are ways that hospitals in Indiana can collaborate with EMS?
  - Hospital Supervision
  - EMS Medical Direction
  - Education and Training – both initial and ongoing
  - Collaboration on systems of care
    - Trauma
    - STEMI
    - Stroke
    - Other time critical diagnoses
  - Outcomes and Feedback
  - Community Paramedicine and Mobile Integrated Health Programs

Why Collaborate?

- For example, an average of 20-30% of patients in the emergency department arrives via ambulance.
- However, of these, a higher percentage are admitted (the national average is 39%), with an average cost exceeding $21,000 per visit.
- Additionally, when an EMS agency chooses your hospital for their higher acuity patients – such as trauma, cardiac, and stroke – the average patient cost is driven even higher.
- All ALS provider EMS agencies in the State of Indiana are REQUIRED by statute to have a supervising hospital and EMS Medical Director.
- Yet, hospitals have no mandate to partner or collaborate with EMS.
- Care begins in the field, as such hospitals should have a vested interest in their community partnerships.

Testimonial

- We have seen a $4 million increase in revenue over the last two years, just from changing our culture. We attribute much of this to increased admission rates from our EMS transports as well more higher acuity patients being delivered to our facilities," Frakes said. "Our EMS agencies know that when coming to our facilities, they will be treated as equals, be shown respect and appreciation, and, more importantly, receive timely and helpful clinical feedback."
- Investing in your relationship with your local EMS agencies can not only create a more efficient environment and better patient outcomes but make a real difference in your hospital's revenue numbers. Improving the teamwork between the two teams is a win-win situation that will undoubtedly benefit your operations for years to come.

Tim Putnam

Diversion

Why YOUR lack of planning shouldn’t be an EMS emergency!

Diversion

- Diversion - The practice of turning away ambulances is known as "ambulance diversion" or "hospital diversion."
  - Is it legal? - Yes
  - Is it enforceable? - No
- Can we ever close our door to walk in patients? – No
  - Then why do we close our door to the one mode of entry that accounts for 20% of our EMS volume?
  - 40% of EMS patients delivered to our door are admitted to the hospital
- What happens if EMS “shows up” with a patient while we are on diversion? – Nothing, we are still obligated under EMTALA to see that patient.

Diversion

Guidance for Hospitals and EMS for Ambulance Diversion Requests

Michael A. Kaufmann, MD, FACEP, FAEMS
State EMS Medical Director
Indiana Department of Homeland Security

- Hospital resources, including emergency services, may occasionally be overwhelmed and may not be able to provide optimal patient care. Factors contributing to this problem include a shortage of qualified health care providers, lack of hospital-based resources, and ongoing hospital and emergency volume in response to COVID19 community transmission.
- While many hospitals have attempted to respond to ED overcrowding by diverting incoming ambulances to other hospitals, diversion creates its own problems, delays patient care, and further reduces our EMS systems ability to respond to calls for emergency assistance in a timely fashion.
- A patient's choice of hospital or other facility should be complied with unless contraindicated by state, regional or system/service protocol or the assessment by a certified EMS provider shows that complying with the patient's request would be injurious or cause further harm to the patient. Patient transfer can be arranged following emergency care and stabilization.

Diversion

- **HOSPITAL DIVERSION REQUESTS**
- A hospital may notify the EMS system of a temporary inability to provide care in the emergency department (ED) and request ambulances divert patients to an alternate hospital facility.
- **A request to divert to another facility may be honored by EMS providers when patient condition and EMS system status allow.**
- A diversion request does not mean the hospital ED is closed, but usually means the current emergency patient load exceeds the Emergency Department's ability to treat additional patients promptly.
- If the patient's condition is unstable and the hospital requesting diversion is the closest appropriate hospital, ambulance service personnel should notify the hospital of the patient's condition and to expect the patient's arrival.
- This procedure should also be followed when a patient demands transport to a facility on diversion.
- A hospital declaring diversionary status for EMS patients is simply a request for EMS to consider an alternate hospital destination. The hospital may not refuse care for a patient presented to their facility and is subject to EMTALA rules and regulations.

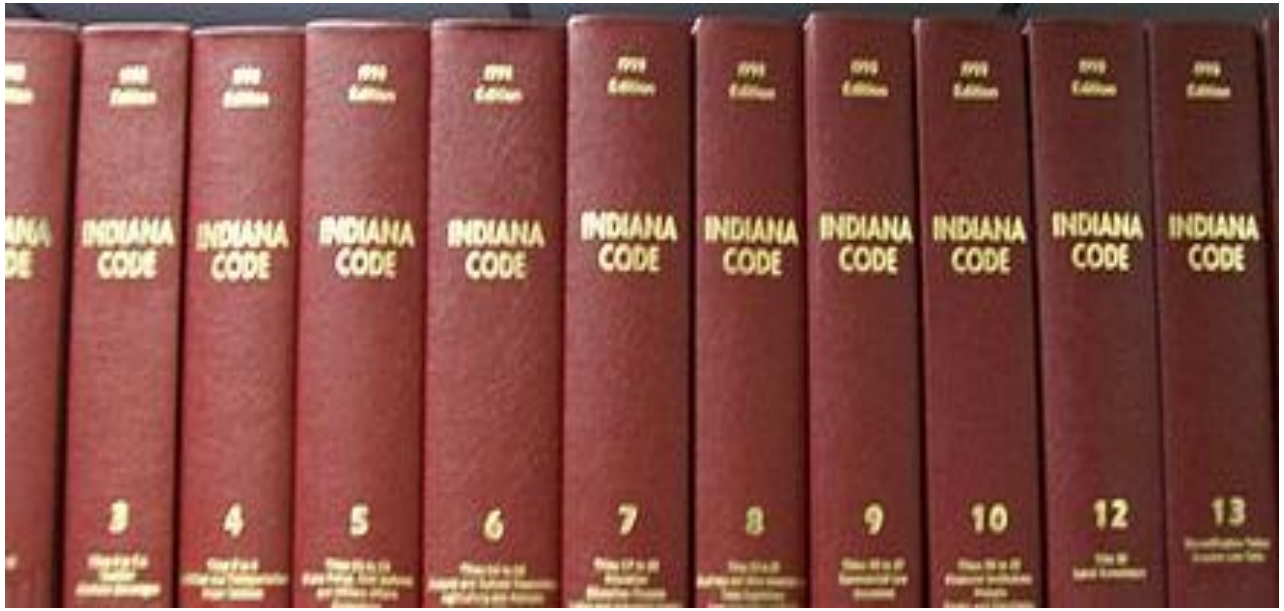
Tim Putnam

Rules, Regulations, and Oversight

& Why Hospital to Hospital Transfers are difficult to mandate

Our Playbook

- The **Indiana Code** is the code of laws for the U.S. state of Indiana. The contents are the codification of all the laws currently in effect within Indiana. These are arranged into 36 Titles,



TITLE 836 RULE RE-WRITE

- Although loosely referred to as a “rule re-write“ this 2019 process reviewed all of the Title 836 language to include:
  - Policy updates approved by the EMS Commission that were not written into rule format.
  - Outdated policy such as old terminology or new practices such as the on-line recertification that was not addressed in rule language.
  - Limited updates to improve the EMS education, certifications, or operations sections.
- Process for rule re-write
  1. Staff developed list of concerns and reviewed the rules section by section.
  2. Preliminary proposals were shared with EMS interest groups such as the Indiana EMS Association (IEMSA), the Indiana Fire Chief’s Association EMS Section (IFCA), and the Indiana EMS Education Working Group.
  3. Modifications were made to the draft which was then submitted to the Indiana EMS Commission over a series of three meetings, including a one-day full day special session devoted to the review.

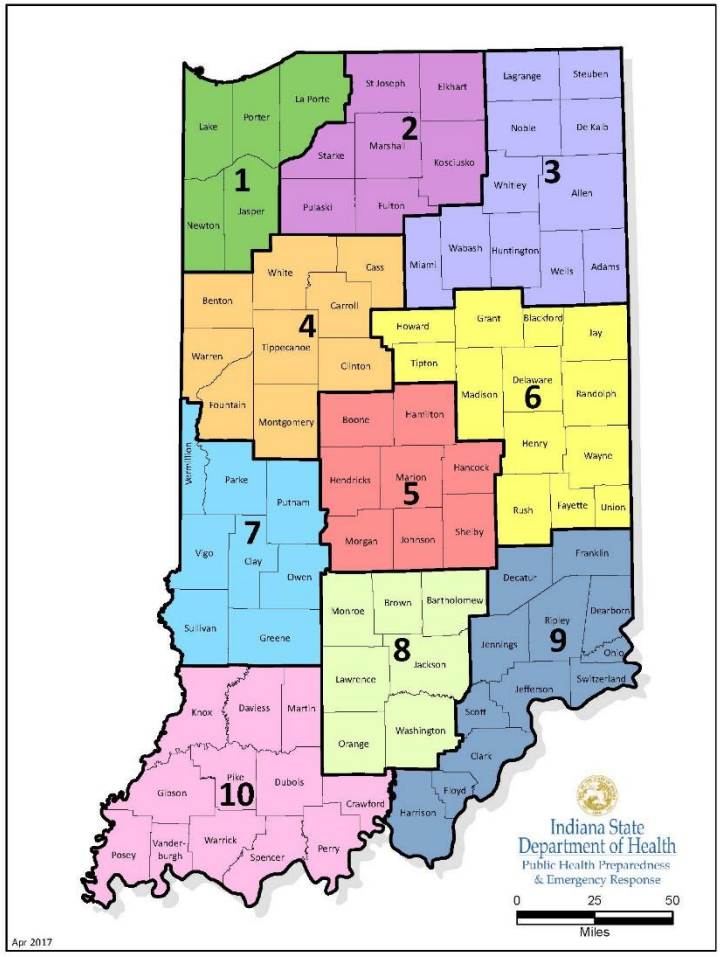
What is the Scope and Intent of the EMS System?

- The first statute of the EMS provisions provides the intent of the EMS legislation:
- ***IC 16-31-1-1 Intent***
- ***Sec. 1. (a) The general assembly declares that the provision of emergency medical services is a matter of vital concern affecting the public health, safety, and welfare of the people of Indiana.***
- *(b) It is the purpose of this article:*
- *(1) to promote the establishment and maintenance of an effective system of emergency medical service, including the necessary equipment, personnel, and facilities to ensure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered;*
- *(2) that the emergency medical services commission established under IC 16-31-2 shall cooperate with other agencies empowered to license persons engaged in the delivery of health care so as to coordinate the efforts of the commission and other agencies; and*
- *(3) to establish standards and requirements for the furnishing of emergency medical services by persons not licensed or regulated by other appropriate agencies.*
- There is a stated intent to provide “prompt and adequate emergency care” in the basic EMS creation statute.
- But who provides those services?

Essential Purpose of Political Subdivisions

- *IC 16-31-1-2 Essential purpose of political subdivisions*
- *Sec. 2. The provision of emergency medical service is an essential purpose of the political subdivisions of the state.*
- This section has been utilized often as it the only statutory provision that addresses a requirement to provide emergency medical services. But the two concerns with the statutory language is
  - 1) what does the provision of emergency medical services entail (eg. BLS or basic life support? ALS or advanced life support? 911 Response? Inter-facility Transfers?)
  - 2) are all political subdivisions (cities, towns, townships, counties) included or is there a paramount one? (eg. if a city does not want to provide EMS, is the county ultimately responsible?)

INDIANA PUBLIC HEALTH PREPAREDNESS DISTRICTS



What is Emergency Medical Services ?

- Statute also helps define emergency medical services (EMS) as:
- IC 16-18-2-110 "Emergency medical services"
- Sec. 110. "Emergency medical services", for purposes of IC 16-31, means the provision of any of the following:
- (1) Emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.
- (2) Transportation services, acute care, chronic condition services, or disease management services provided as part of a mobile integrated healthcare program under IC 16-31-12.

Application Questions

Application #1 Who is required to provide emergency medical services as a political subdivision?

This could be addressed by a rule tailored to address who is responsible. However, there might be a large fiscal impact and lot of fighting about the rule. The best body to consider this question is the legislature due to the complex political ramifications.

Application #2 Is ALS required to be provided?

Again, this could be added via rule promulgation. If the EMS Commission would adopt rules that indicate that "emergency medical services" means ALS would ensure that all persons receive appropriate care in the Intent statute, then I believe every political subdivision would be required to have ALS. However, this one would also have a heavy fiscal impact. The best body to consider this question is the legislature due to the complex political ramifications.

Application Question #3

Application #3 Would hospital transfers be required for provider organizations?

There is an argument that a patient in a facility in need of transport to another facility for more definitive care is still an "emergency." Per IC 16-18-2-110, an " individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury" is considered EMS and thus subject to regulation by the EMS Commission, Generally, the EMS Commission and IDHS do regulate ambulances performing these services. However, the question is whether there is mandate to provide ambulance services to facilities as part of EMS regulatory oversight. There is not. If the EMS Commission elected to, it likely could create rules to clarify the matter. However, like the above considerations, there would large implications on ambulance service providers and even political subdivisions that provide EMS. Generally the transportation of patients from one patient facility to another while a service to that patient, also benefits the transferring facility in avoiding liability for failure to appropriately treat. The EMS Commission nor IDHS currently require any provider organization to perform any specific response, but rather requires certification if EMS activity is being conducted. The obligation to provide response is generally governed by contract. For instance, a 911 coverage contract, an agency of a branch of local government, or other types of agreement create the duty to respond to 911 or other types of calls. There is not a basic duty to respond to a facility to transfer a patient. That is something that the transferring hospital must arrange for and can do so via contractual agreements. IDHS could be of assistance by helping a hospital connect with provider organizations near that area that might be interested in provider inter-facility transports.

Tim Putnam

EMS Reimbursement in 2021

Where we are and why we must continue to evolve

Future Direction on the Reimbursement Issue

- In 2016, The National Academy of Sciences published “A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths after Injury”.
- Recommendation 10: Congress, in consultation with the U.S. Department of Health and Human Services, should identify, evaluate, and implement mechanisms that ensure the inclusion of prehospital care (e.g., emergency medical services) as a seamless component of health care delivery rather than merely a transport mechanism.
- The cost to deliver standard prehospital care and during interfacility transports is rapidly increasing to include expensive cardiac monitor / defibrillators, rising medications costs, ventilators, expensive medical record systems which integrate with hospitals and gather standardized data elements, etc.
- EMS agencies are not reimbursed for any of the supplies used during an encounter but are instead paid a fixed amount only for transported patients. The cost to deliver care per response is frequently greater than the fixed reimbursement for that response. Insurance companies will not reimburse life-saving care by one agency if another agency provides transport, for instance, by air ambulance.
- EMS responses without transport may represent up to 30 % of calls in a system.

The EMS System in Indiana

- Unfortunately, Ambulances are considered “transportation” and not healthcare.
- As such, they have historically been reimbursed ONLY for transportation (not medical care provided.)
- Even though Indiana statute states EMS is an “Essential” service, there is no mandate or requirement that it be provided to the public.
- The responsibility to provide EMS services rests with the “local jurisdiction of government.”
- There is no mandate to provide funding for EMS services.
- Some counties are covered on a completely fee for service basis while other EMS provider agencies receive tax subsides to cover their cost of readiness.
- This system is heavily weighted toward the urban 911 response leaving many counties and hospitals uncovered for emergency patients and interfacility transfers.

What's Been Done to Address the Issue?

- Band aid fixes and piece meal patches
  - CMS waiver for ground ambulance services: Treatment in place
  - IHCP announces EMS provider relief funding due to pandemic
  - Naloxone reimbursement – an Indiana first
  - Vaccine administration – another Indiana first
  - HEA – 1209 – another Indiana first

- Future Fixes
  - Medicare and Medicaid rate increases
  - Change reimbursement at a federal and state level to reflect care rendered rather than miles transported
  - Use quality metrics for incentive payments
  - Fix the services ordered vs. services rendered gap
  - Further engage EMS into healthcare and public health and reimburse accordingy

Tim Putnam

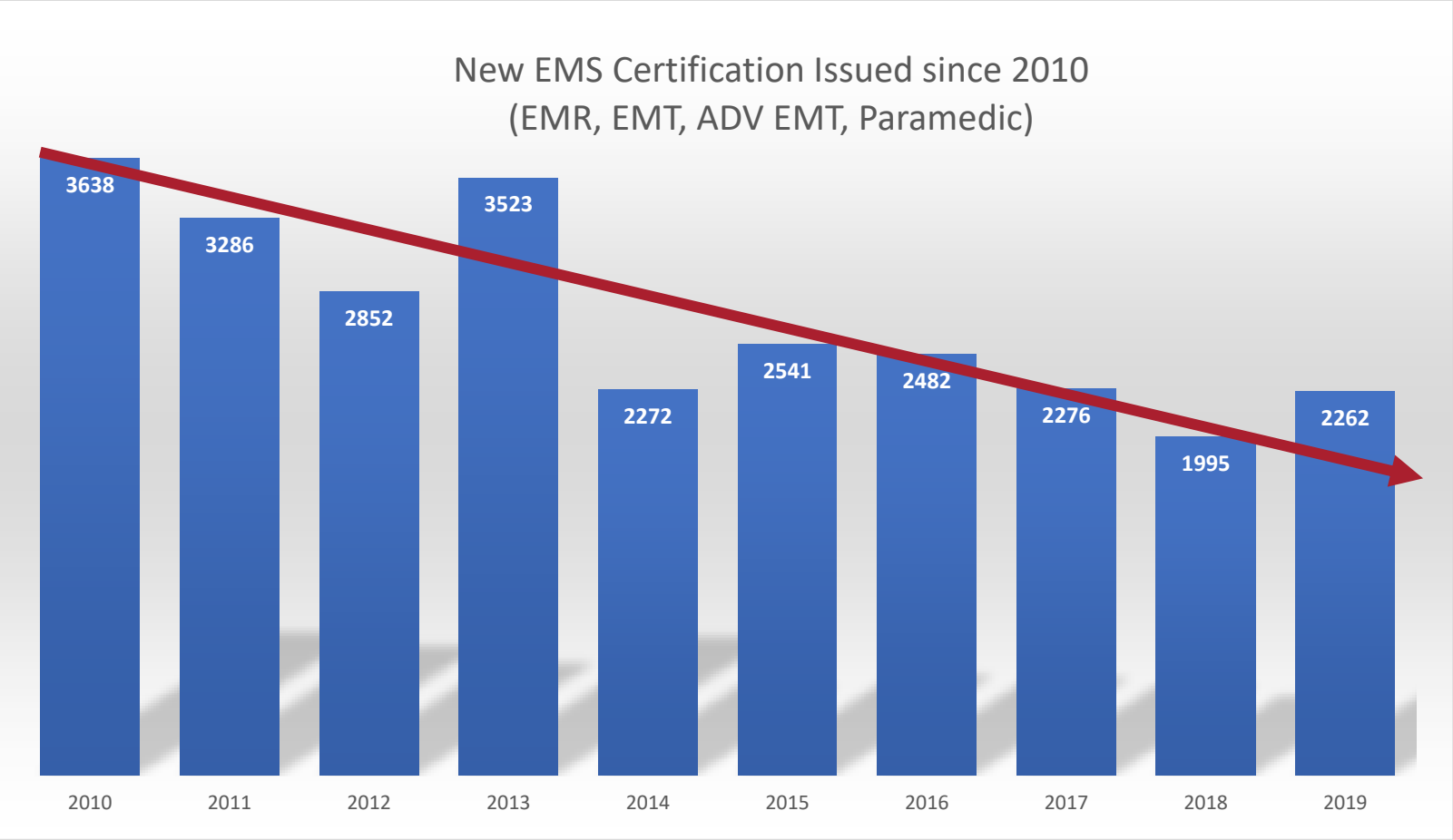
Workforce Issues and Training Programs

Why our declining EMS workforce isn’t going to end soon.

Workforce Issues

- Indiana has a critical shortage of EMTs and Paramedics.
- Many agencies are now short staffed and unable to fill their schedules.
- As such, ambulances and sitting idle without staffing.
- We've done what we can to ease the demand.
  - EMS Compact State
  - Waivers on staffing
  - Waivers on availability
- This is a complex issue and there is not quick fix.
  - EMS reimbursement for care is low.
  - Care has evolved over the last 50 years, but EMS reimbursement has not.
  - Certification/licensure is costly, wages and salaries have not kept up with demand or inflation and do not accurately reflect EMS as a healthcare provider.
  - It pays more to get an unskilled job in a warehouse or food service industry.

New Certifications Issued



Academic EMS Courses Statewide 2019 vs 2020

- 2019:
- EMR – 113
- EMT – 174
- AEMT – 12
- Paramedic – 7
- Primary Instructor – 14

- 2020:
- EMR – 76
- EMT – 152
- AEMT – 6
- Paramedic – 9
- Primary Instructor – 17

Highschool based EMS education courses and community college based courses have the lowest passing rates in the State.

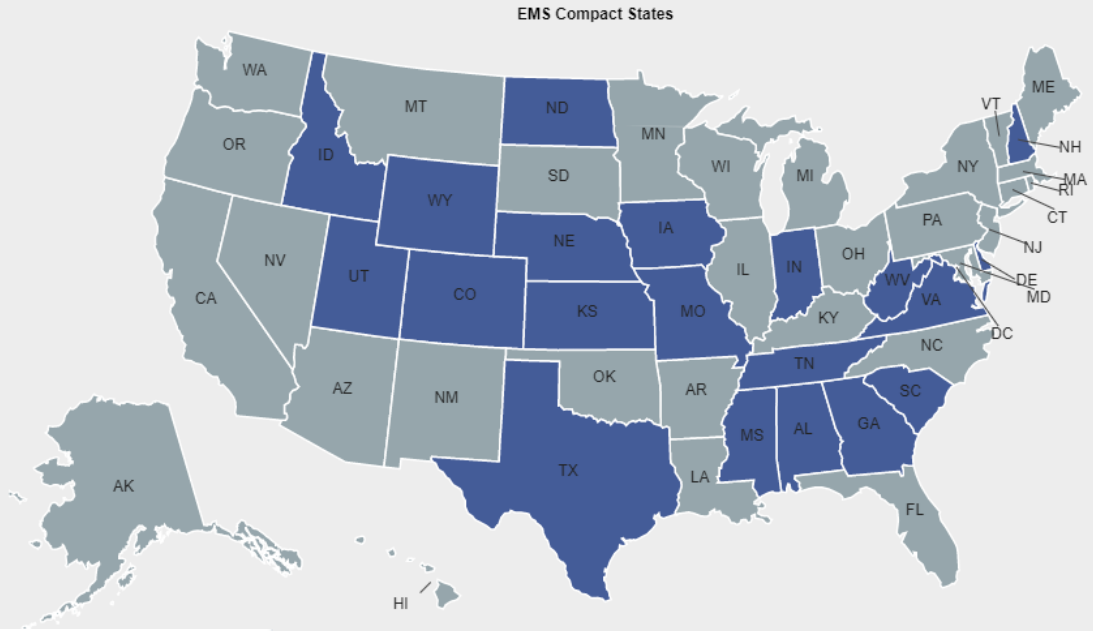
Hospital bases courses have the highest passing rates.

How do we encourage more hospital based involvement in EMS education and operations?

EMS Compact

Interstate Commission for EMS Personnel Practice
The EMS Compact

EMS Compact Member States & Commissioners



Multi-State Privilege To Practice

REPLICA extends a multi-state privilege to practice to qualified EMS personnel.

- Senate Enrolled Act 61 adopts the EMS Compact for Indiana.
- RECOGNITION OF EMERGENCY MEDICAL SERVICES PERSONNEL LICENSURE INTERSTATE COMPACT (“REPLICA”) is the nation's first and only multi-state compact for the Emergency Medical Services profession.
- The EMS Compact provides qualified EMS professionals licensed in a "Home State" a legal "Privilege To Practice" in "Remote States".
- Home States are simply a state where an EMT or Paramedic is licensed;
- Remote States are other states that have adopted the EMS Compact legislation

EMS Compact

Healthcare System Utilization

- Likewise, the pandemic created a need for more skilled providers in the healthcare setting.
- RN staffing requires nurses to do more with less.
- As such, many healthcare systems have begun employing EMTs and paramedics to work alongside nurses, NPs, Pas, and MDs to help extend their reach and increase their patient loads.
- This further strains our pool of EMS provdiders to staff ambulances and other emergency apparatus.

Tim Putnam

Future Direction and Opportunity for Better Care

A look at MIHCP

Building One Indiana

Governor Holcomb's 2020 Next Level Agenda

Economy

Tell Indiana's story by starting up the new Indiana Destination Development Corporation & attracting more jobs & talent

Leverage our defense assets & **triple Department of Defense investment** in Indiana

Infrastructure

Parks
Rehab & renovation

Roads
Build, preserve & enact hands-free device driving law

Rail
West Lake & South Shore

River
Fourth port

Runways
Nonstop international flights

Finish **$190M investment in broadband & trails**

Deploy **$436M for water quality**

Workforce & Education

Support Teacher Compensation Commission in **making teacher pay more competitive**

Eliminate unnecessary requirements in 2021

Change career-related teacher professional growth points from **required to optional**

Hold schools harmless for 2018-19 ILEARN scores

Redesign prison education credits to better prepare offenders for re-entry

Public Health

Raise smoking, vaping age to 21 & enhance enforcement

Make **health care costs more transparent** for consumers

No surprise billing

Add **more recovery housing** & **expand pilot program** for jail inmates

Require **school relationship** with a mental health provider

Increase **mental health** professionals & services

More community **paramedicine** programs

Provide **more accommodations for pregnant workers**

Good Government

Use $300M in reserves to **pay for capital projects** that will save more than $125M in borrowing costs

Improve & expand 2-1-1 call services to help more Hoosiers

EMS Agenda for the Future (Circa 1996)

- Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will have the ability to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. This new entity will be developed from redistribution of existing health care resources and will be integrated with other health care providers and public health and public safety agencies. It will improve community health and result in more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net.

EMS Solutions

- This new delivery of care methodology was called Mobile Integrated Healthcare or Community Paramedicine (MIH-CP)
  - These programs identified gaps in healthcare resources
  - Engaged EMS in finding solutions to those gaps

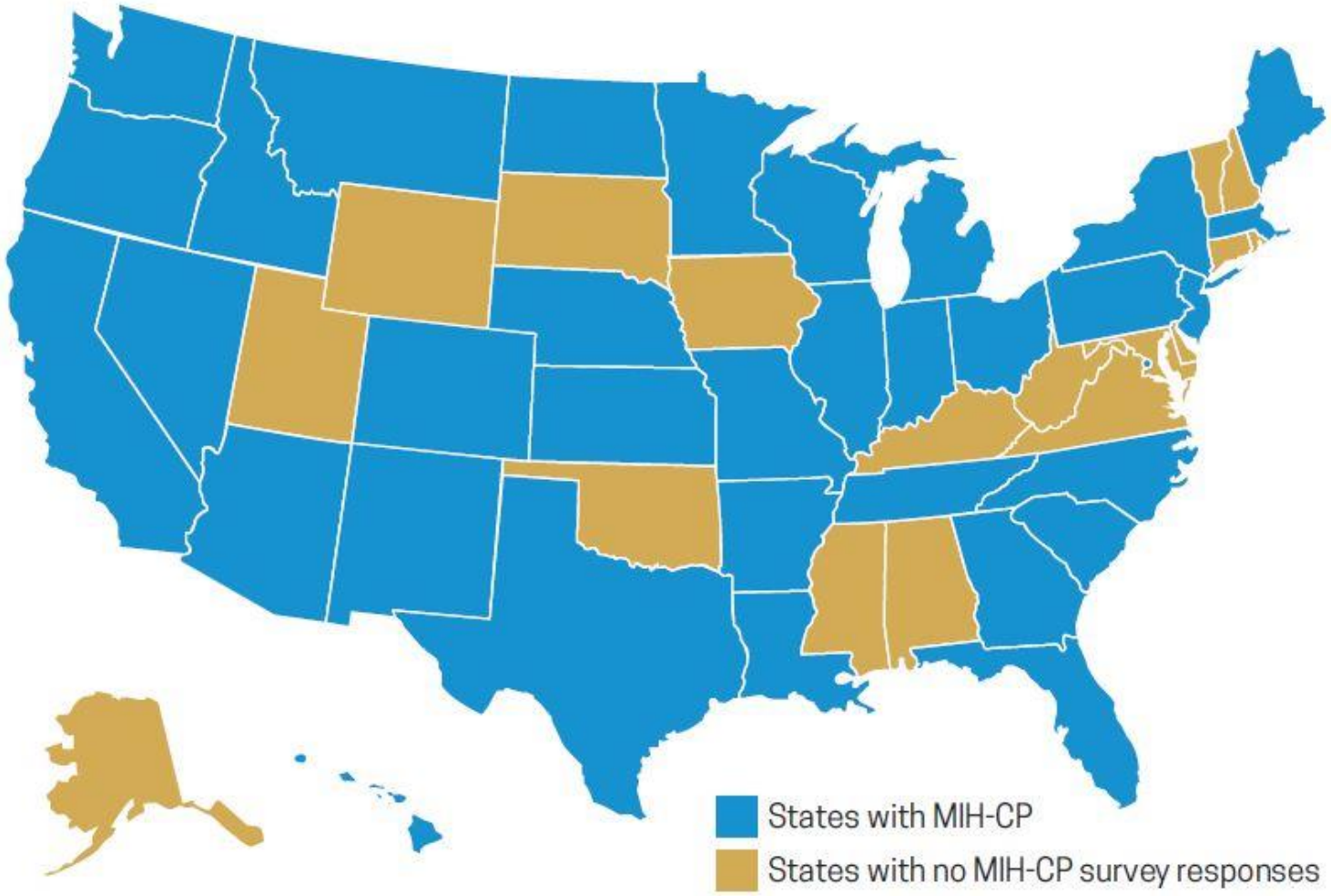
- Central Premise Unique to MIH-CP
  - EMS providers are trained and trusted medical professionals
  - Available 24/7
  - Accustomed to working in the field
  - Embedded in every community in the nation

MIH-CP

- Services may include:
  - Sending EMTs and paramedics into the homes of patients to help with chronic disease management and education
  - Visiting post-hospital discharge follow-up to prevent hospital admissions or re-admissions
  - Navigating patients to destinations such as primary care, urgent care, mental health, or substance abuse treatment centers instead of ERs.
  - Providing telephone triage, advice or other assistance to non-urgent 911 callers instead of sending an ambulance crew.
  - Using telemedicine technology to facilitate interactions between patients in their home and medical professionals in hospitals or other locations.

MIH-CP in Action

- MIH-CP currently offered in 33 states plus Washington, D.C.
  - 70% consider themselves CP
  - 30% consider themselves MIH



MIHCP Targets

- Preventing hospital readmissions
- Reducing frequent ED and EMS utilizers
- Chronic disease management in rural areas
- Alternate destinations
- Home health support
- Primary care extender
- Hospice support
- 911 Nurse Triage

EMS Commission Update

- **MIH-CP Advisory Board**
  - Dedicated MIH-CP board with seats representing the diverse stakeholders in MIH-CP in Indiana, including but not limited to:
  - State EMS Medical Director — Michael Kaufmann
  - State EMS Director — Kraig Kinney
  - EMS Medical Director Rep. — Eric Yazel
  - MIH-CP Program Director — Paul Miller
  - Municipal EMS MIH-CP Program — Steve Davison
  - Non-municipal MIH-CP Program — Chad Owen
  - College/University — Laura Schwab-Reese
  - MIH-CP Provider — Shane Hardwick
  - MIH-CP Patient — TBD
  - FSSA Representative — Dr. Sullivan
  - Insurance Industry Representative — Keith Mason, United Healthcare
  - ISDH Representative — Dr. Box/Dr. Weaver
  - IHA Representative — Andy VanZee
  - IEMSA Representative — Nate Metz
  - IFCA Representative — Douglas Randall

Tim Putnam

Summary

- Indiana EMS is a dynamic and ever-changing system.
- EMS stands ready at the intersection of public safety, public health, and healthcare
- IDHS is proactively working to improve the way EMS operates.
- Many challenges face EMS in the days to come.
  - Hospital Culture
  - Diversion Issues
  - Rules, Regulation, Oversight
  - EMS Reimbursement
  - A declining workforce
- MIHCP is an opportunity for further engage EMS in the health of our communities.

QUESTIONS?
COMMENTS?
FEEDBACK?

THANK YOU!

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PATRIOTS


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