



National Emergency Medical Services Advisory Council

December 22, 2014

Aarron Reinert

Chair

Kyle Gorman

Vice-Chair

Drew Dawson
Designated Federal Official
National Emergency Medical Services Advisory Council
1200 New Jersey Avenue, S.E.
Washington, DC 20590

Dear Mr. Dawson:

At its meeting of December 4, 2014, the National Emergency Medical Services (EMS) Advisory Council voted unanimously to accept the final draft minimal updates to the *EMS Education Agenda for the Future* requested by your office and recommend them for your approval and dissemination amongst the EMS stakeholder organizations and communities of our nation.

As you are aware, given the input provided to us by our EMS colleagues throughout the United States, only minimal updates to the *EMS Education Agenda for the Future* were contemplated at the present time, deferring substantive revision until a later date should it prove to be necessary. However, during the process of soliciting input from our EMS colleagues, it became clear that there were several issues that might be considered during a potential revision at some future time. These were termed “parking lot” issues, since we had no mandate from your office to incorporate them into the minimal updates they requested, yet represented important issues we judged worthy of further discussion at a more propitious time in the evolution of EMS education.

Both documents, the minimal updates to the *EMS Education Agenda for the Future*, and the “Parking Lot” issues described above, are attached to this letter. Thank you for the opportunity to take on this essential work for the Office on behalf of the EMS education system of the nation. Please let us know if there is anything else we can do to assist in the completion of this vital task.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Aarron Reinert".

Aarron Reinert
Chair

Attachments

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Preamble

In 2012, the National Emergency Medical Services Advisory Council (NEMSAC) convened a national Roundtable on the *EMS Education Agenda for the Future*. The Roundtable brought together stakeholders from across the entire spectrum of EMS to provide input on the *National EMS Education Agenda for the Future: a Systems Approach (Education Agenda)*. The EMS stakeholder message was clear: many states and localities have only recently begun to experience the full impact of the evolution toward a nationally integrated system of education for EMS personnel. Any major revision or change in direction of the *Education Agenda* could interfere with its ongoing implementation.

The NEMSAC therefore recommended only minimal updates to the *Education Agenda* to ensure it remains contemporary yet still remains aligned with the views of EMS stakeholders that major revision could interfere with ongoing implementation. It then invited public comment regarding the breadth and depth of those updates. Specifically, the NEMSAC sought public comment on key educational issues that were not yet part of the EMS landscape in June 2000 when NHTSA first published the *Education Agenda*. The results of this public comment are broadly summarized by the following NEMSAC recommendations:

- Prehospital care protocols must be evidence-based in order to provide the highest level of care and greatest protections for the patient population.
- With the content flexibility afforded by the Education Standards, EMS educational programs should use a nationally accepted set of evidence-based model EMS clinical guidelines and other evidence-based guidelines (EBGs) to drive local curriculum development.
- To assist with the transition to EBGs, EMS educational programs can reference national guides and tools consistent with the National Prehospital EBG Model Process that was approved by the National EMS Advisory Council (NEMSAC) and the Federal Interagency Committee on EMS (FICEMS).

In addition to the identified NEMSAC recommendations, the following are key issues that were reviewed, but were considered beyond the scope of the minimal updates requested by EMS stakeholders at the present time, but may be embedded in future EMS educational initiatives:

- Future data and information analysis initiatives (e.g., NEMSIS, evidence-based research, practice analysis and other sources) may demonstrate alternative and improved methods of delivering prehospital care. Similarly, medical advances and discovery will drive changes to each *Education Agenda* component. These changes will allow the entire EMS system to provide patient care based on the best available scientific knowledge. NHTSA, in cooperation with Federal and non-Federal stakeholders, will develop a plan for reviewing and updating the components.
- Mobile integrated healthcare has received considerable attention from the EMS community. This healthcare delivery model utilizes EMS personnel to provide non-emergency care that may prevent future hospitalizations and potentially improve patients' quality of life. This is often achieved at a lower total cost of care. In many cases, EMS

personnel involved in this healthcare delivery model receive additional training and education and may require an expanded, but community-based, scope of practice.

- A foundation of knowledge that will enable EMS providers to potentially modify their roles in response to the changing health care system and emerging health care crises.
- The Patient Protection and Affordable Care Act (PPACA) specifically lists members of the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services) as health professionals.

This document represents the minimal updates based on current evidence recommended by the NEMSAC and adopted by the National Highway Traffic Safety Administration (NHTSA). RED typeface in the document represents the suggested minimal updates to the original *Education Agenda*.

THE VISION

Emergency medical services (EMS), as a profession, is now barely a generation old. All of us working in the EMS professions recognize the enormous debt of gratitude that we owe to our predecessors for the astounding progress that has been made during our professional lifetimes in all aspects of the field, including education. We now have the opportunity to honor their foresight, and build upon the solid foundation they created, by designing a structure for the EMS education system worthy of their dreams and aspirations for us, their successors. We owe it to them, ourselves, and our patients to carry on the work our predecessors began, in a way that extends their vision far into the next millennium.

In 1996, the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration (HRSA) published the highly regarded consensus document titled the *EMS Agenda for the Future*, commonly referred to as the *Agenda*. This was a federally funded position paper completed by the National Association of EMS Physicians (NAEMSP) in conjunction with the National Association of State EMS Directors (NASEMSD). The intent of the *Agenda* was to create a common vision for the future of EMS. This document was designed for use by government and private organizations at the national, state, and local levels to help guide planning, decision making, and policy regarding EMS. The *Agenda* addressed 14 attributes of EMS, including the EMS education system.

The *Agenda* provided the following overall vision for EMS in the future:

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 a more appropriate use of acute health care resources. EMS will remain the public's emergency medical safety net.

The following vision of EMS education is paraphrased from the *Agenda*:

EMS education in the year 2010 develops competence in the areas necessary for EMS providers to serve the health care needs of the population. Educational outcomes for EMS providers are congruent with the expectations of the health and public safety services that provide them. EMS education emphasizes the integration of EMS within the overall health care system. In addition to acute emergency care, all EMS educational programs teach illness and injury prevention, risk modification, the treatment of chronic conditions, as well as community and public health.

EMS education is of high quality and represents the intersection of the EMS professional and the formal educational system. The content of the education is based on National EMS Education Standards (*Education Standards*). There is significant flexibility to adapt to local needs and develop creative instructional programs. Programs are encouraged to excel beyond minimum educational quality standards. EMS education is based on sound educational principles and is broadly recognized as an achievement worthy of formal academic credit.

Basic level EMS education is available in a variety of traditional and non-traditional settings. Advanced level EMS education is sponsored by institutions of higher education, and most are available for college credit. Multiple entry options exist for advanced level education, including bridging from other occupations and from basic

EMS levels for individuals with no previous medical or EMS experience. All levels of EMS education are available through a variety of distance learning and creative, alternative delivery formats.

Educational quality is ensured through a system of accreditation. This system evaluates programs relative to standards and guidelines developed by the national communities of interest. Entry level competence is ensured by a combination of curricula standards, national accreditation, and national standard testing.

Licensure is based upon the completion of an approved/accredited program and successful completion of the national exam. This enables career mobility and advancement and facilitates reciprocity and recognition for all levels.

Interdisciplinary and bridging programs provide avenues for EMS providers to enhance their credentials or transition to other health career roles and for other health care professionals to acquire EMS field provider credentials. They facilitate adaption of the workforce as community health care needs, and the role of EMS, evolves.

In December 1996, NHTSA convened an EMS Education Conference with representatives of more than 30 EMS-related organizations to identify the next logical *Agenda* implementation steps for the EMS community. The outcome of this meeting is broadly summarized by the following recommendations:

- The *National EMS Education and Practice Blueprint (Blueprint)* is a valuable component of the EMS education system. It should be revised by a multi disciplinary panel, led by NHTSA, to more explicitly identify core educational content for each provider level.
- ~~National EMS~~ *Education Standards* are necessary, but need not include specific declarative material or lesson plans. NHTSA should support and facilitate the development of ~~National EMS~~ *Education Standards*.
- The *Blueprint* and ~~National EMS~~ *Education Standards* should be revised periodically (major revision every 5 to 7 years, ~~minor~~ *minimal* updates every 2 to 3 years).

In January 1998, NHTSA formed a Blueprint Modeling Group to develop procedures for revising the *Blueprint*. During their initial deliberations, the group determined that the *Blueprint* should be only one component of a more comprehensive EMS education system of the future. Consequently, they changed their name to the EMS Education Task Force. They expanded their goal to include defining both the elements of the education system and the interrelationships necessary to achieve the vision of the *Agenda*. This document, the *EMS Education Agenda for the Future: A Systems Approach (Education Agenda)*, is the result of their deliberations.

Update 2015

In 2012, the National Emergency Medical Services Advisory Council (NEMSAC) convened a national Roundtable on the *EMS Education Agenda for the Future*. The Roundtable brought together stakeholders from across the entire spectrum of EMS to provide input on the *National EMS Education Agenda for the Future: a Systems Approach (Education Agenda)*. The EMS stakeholder message was clear: many states and localities have only recently begun to experience the full impact of the evolution toward a nationally integrated system of education for EMS personnel. Any major revision or change in direction of the *Education Agenda* could

interfere with its ongoing implementation.

The NEMSAC therefore recommended only minimal updates to the *Education Agenda* to ensure it remains contemporary yet still remains aligned with the views of EMS stakeholders that major revision could interfere with ongoing implementation. It then invited public comment regarding the breadth and depth of those updates. Specifically, the NEMSAC sought public comment on key educational issues that were not yet part of the EMS landscape in June 2000 when NHTSA first published the *Education Agenda*. The results of this public comment are broadly summarized by the following NEMSAC recommendations:

- Prehospital care protocols must be evidence-based in order to provide the highest level of care and greatest protections for the patient population.
- With the content flexibility afforded by the Education Standards, EMS educational programs should use a nationally accepted set of evidence-based model EMS clinical guidelines and other evidence-based guidelines (EBGs) to drive local curriculum development.
- To assist with the transition to EBGs, EMS educational programs can reference national guides and tools consistent with the National Prehospital EBG Model Process that was approved by the National EMS Advisory Council (NEMSAC) and the Federal Interagency Committee on EMS (FICEMS).

The EMS stakeholder community also felt academic preparation of EMS faculty is critical. A new EMS educator often finds that field experience provides little training in the science or practice of education. In order to assist the EMS provider of the future with the knowledge and skills necessary to provide evidence-based care, EMS educators must possess a solid background in adult learning theory, adult learner characteristics, effective and reliable assessment and feedback techniques, curriculum development, and formal presentation skills.

The NEMSAC therefore fully supports efforts of EMS educators to enhance their academic preparation, but offers no specific recommendations as to how this may best be achieved, as this is beyond the scope of the minimal updates requested by EMS stakeholders at this time.

Milestones in the Education Agenda

Table 1 outlines key events in the development of the *Education Agenda*.

TABLE 1: Historical Development of the EMS <i>Education Agenda</i>	
Year	Milestone
1993	National Registry of Emergency Medical Technicians (NREMT) endorses the <i>National EMS Education and Practice Blueprint (Blueprint)</i>
1996	<i>EMS Agenda for the Future</i> published by NHTSA and HRSA
1996	NHTSA convenes an EMS Education Conference. One of the key recommendations is for NHTSA to bring together a group to revise the <i>Blueprint</i> .

1998-2000	NHTSA convenes an EMS Education Task Force to revise the <i>Blueprint</i> . The task force expands their mission and creates the <i>National EMS Education Agenda for the Future: A Systems Approach (Education Agenda)</i> .
2005	<i>National EMS Core Content (Core Content)</i> published by NHTSA and HRSA
2007	<i>National EMS Scope of Practice Model (Scope of Practice)</i> published by NHTSA and HRSA
2007	NREMT Board of Directors votes to require that paramedic applicants for certification graduate from an “accredited” paramedic program effective January 1, 2013.
2009	<i>National EMS Education Standards and Instructional Guidelines</i> published by NHTSA and HRSA
2010	The National Association of State EMS Officials (NASEMSO) adopts resolution recognizing the importance of national EMS certification and national EMS program accreditation by single national agencies as provided by NREMT and the Committee on Accreditation of Emergency Medical Services Professions (CoAEMSP)
2012	NEMSAC hosted a national “Roundtable on the <i>EMS Education Agenda for the Future</i> ” and recommended minimal updates to the <i>Education Agenda</i>

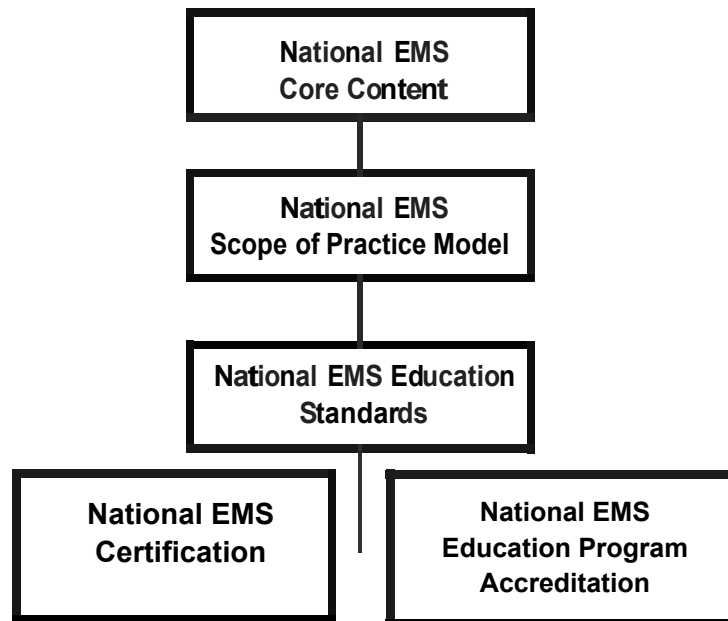
EXECUTIVE SUMMARY

The *Education Agenda* is a vision for the future of EMS education, and a proposal for an improved structured system to educate the next generation of EMS professionals. The *Education Agenda* builds on broad concepts from the 1996 *Agenda* to create a vision for an education system that will result in improved efficiency for the national EMS education process. This system will enhance consistency in education quality and ultimately lead to greater entry level graduate competence.

The *Education Agenda* was developed by a task force representing the full range of professions involved in EMS education, including EMS administrators, physicians, regulators, educators, and providers. This document proposes an education system with five integrated primary components:

- National EMS Core Content
- National EMS Scope of Practice Model
- National EMS Education Standards
- National EMS Education Program Accreditation
- National EMS Certification

The proposed system maximizes efficiency, consistency of instruction quality, and student competence by prescribing a high degree of structure, coordination, and interdependence among the five components.



1
2 A key benefit of this systems approach will be an enhancement of the consistency of instructional quality
3 achieved through an interaction among three system components, the ~~National-EMS~~ *Education Standards*,
4 National EMS Education Program Accreditation (**Program Accreditation**), and National EMS Certification
5 (**EMS Certification**). At the higher levels of education, this strategy for ensuring consistency allows the use
6 of less prescriptive ~~National-EMS~~ *Education Standards* in place of the current *National Standard*
7 *Curricula* (NSC). With less dependence on a prescriptive NSC, instructors will have greater flexibility for
8 targeting instruction to specific audiences, resulting in enhanced comprehension and improved student
9 competence.

10
11 The *Education Agenda* describes an interdependent relationship among the five system components and
12 recommends specific lead groups for development and revision responsibilities.

- 13
14 • The ~~National-EMS~~ *Core Content* is a comprehensive list of skills and knowledge needed for out-of-
15 hospital emergency care. Specification of the *Core Content* is primarily a medical concern and will be
16 led by the medical community, with input from the system regulators, educators, and providers.
- 17
18 • The ~~National-EMS~~ *Scope of Practice Model* divides the ~~National-EMS~~ *Core Content* into levels of
19 practice, defining minimum knowledge and skills for each level. Since this determination is
20 fundamentally a system issue, the system regulators will have the lead in its development, with input
21 from the other stakeholders.
- 22
23 • The ~~National-EMS~~ *Education Standards* take the place of the current ~~National Standard Curricula~~
24 *MSC*, specifying minimum terminal learning objectives for each level of practice. Being basically an
25 educational task, the development of the ~~National-EMS~~ *Education Standards* will be led by educators,
26 with input from other stakeholders.
- 27
28 • ~~National-EMS Education~~ Program Accreditation is applied to all nationally recognized provider
29 levels and is universal. Accreditation is the major mechanism for verifying educational program
30 quality for the protection of students and the public. Accreditation enhances the consistency of the
31 evaluation of instructional quality.
- 32
33 • ~~National~~ EMS Certification is available for all nationally recognized provider levels and is universal.
34 Certification involves a standardized examination process and contributes to the protection of the
35 public by ensuring the entry-level competence of EMS providers. In order to be eligible for ~~National-~~
36 EMS Certification, a student must have graduated from an accredited program.

37
38 Administratively, the system proposed in the *Education Agenda* offers a number of benefits, including
39 greater predictability for component development cycles and a clear and definite method for introducing
40 changes to the system. These provisions will clarify the process for accommodating medical advances,
41 technology development, and other needs that affect the scope or content of EMS education while
42 following the recommendations of the 1996 *Agenda*.

INTRODUCTION

Since its inception, emergency medical services (EMS) education has evolved and matured. As is true of most new professions, no “master plan” was conceived to guide its evolution systematically. Effective components of quality EMS education have emerged during the last thirty years, including national standard EMS curricula, accreditation standards, and a national registration system. Unfortunately, these individual parts have developed independently, and currently there is no formal EMS education *system* in which the components are clearly defined, their interrelationships articulated, and the decision-making process for modification and improvement established.

In the 1970s, the stakeholders of EMS had no way to predict the challenges that would face the profession in its rapid growth period. The diversity of EMS providers (from ~~paid, full-time career to~~ volunteer personnel), system design (hospital-based to public safety-based), and local variations of practice have presented unique challenges that do not face other allied health care professions.

Although many outstanding EMS providers have been educated during the last 30 years, the absence of a structured education system has resulted in considerable state-by-state variability in EMS education and licensing standards and a lack of clear-cut future direction. The absence of a formal EMS education system has also led to inconsistencies among the various curricula and difficulties in the ability to bridge from one level of education to another. Currently, there is no consistent method of providing input to the national EMS education decision-making process. In addition, the ~~national standard curricula~~ *NSC* now allow limited instructor flexibility and are infrequently updated.

EMS education is at a crossroads in its evolution. As identified in the 1996 *Agenda*, there are numerous challenges to preparing EMS providers for their evolving role in the health care system. Clearly, there is the need for a national *system* of EMS education.

The Purpose

The *Education Agenda* describes a consensus vision for the EMS education system of the future. This document describes the elements of an educational system and their interrelationships. The document is conceptual; it is expected that the specific details of development and implementation will evolve as the components of the system develop.

This vision for the EMS education system of the future will accommodate the increasing sophistication and changing nature of EMS. It will clarify the educational decision-making process, and establish avenues for input and research. This proposal will promote national consistency, but is flexible enough to accommodate state and local variations. These concepts will enable timely changes in patient care.

The *Education Agenda* defines a system that will benefit states by avoiding duplication of effort in curriculum development, testing/certification/licensure, and educational program approval, and help facilitate provider reciprocity.

1
2 The synergistic effects of the system are enormous; clearly, the whole is greater than the sum of its
3 parts. The proposed system infrastructure will outlive its architects and ensure a viable framework for
4 national EMS education decision making and future planning.
5

6 **Evolution of Allied Health Education**

7

8 As the sophistication and complexity of medical care increased, the 1960s saw a number of allied health
9 professions join the ranks of nurses and physicians to provide care to patients in this country. In
10 1966, Congress passed The Allied Health Professions Training Act. This legislation provided a formal
11 system of physician-directed practice and gave the American Medical Association (AMA) the authority to
12 grant authorization to institutions that sponsor and provide instruction to allied health professionals.
13

14 Through the Commission on Allied Health Education Accreditation (CAHEA), the AMA developed a
15 system that accredited educational institutions to conduct allied health educational programs. The CAHEA
16 model of accreditation (now administered by the Commission on Accreditation of Allied Health Education
17 Programs or CAAHEP) was similar to the process used by nursing and medical schools. Each recognized
18 allied health occupation developed a Joint Review Committee (JRC), consisting of membership from
19 physician and professional associations. With broad community input, each JRC was charged with
20 developing essentials or standards which would be used as the basis of evaluating and accrediting
21 programs.
22

23 Throughout the past three decades, allied health professions experienced a transition from on-the- job
24 training to education in formal institutions of higher education. Initially, most allied health education
25 programs were sponsored by health care institutions. However, since the late 1960s there has been a rapid
26 and steady trend toward collegiate and university settings. Most allied health fields instituted more and
27 better training and have adopted educational requirements that include formal academic degrees (Farber
28 and McTernan, 1989). By 1980 more than half the allied health programs in the United States were
29 housed in collegiate settings (Ford, 1983). By 1998 there were 16 accrediting agencies and 47 recognized
30 allied health occupations (AMA, 1998).
31

32 Most allied health programs have a registration or certification process that is national in scope and
33 typically sponsored by a professional association. Although there are some exceptions, eligibility for
34 registration or certification is typically limited to individuals who have graduated from accredited training
35 programs. Since authorization to practice is a state function, state licensure is usually granted to individuals
36 who have completed the examination process established or endorsed by the profession.
37

38 **Evolution of EMS Education**

39

40 A look at the past frequently can help us to understand the present and to plan for the future. The history of
41 EMS education is largely synonymous with the history of emergency medical services systems. The
42 pioneers in EMS clearly valued strong educational programs as much as we do today. Following is a
43 historical summary of EMS education, highlighting issues that are important to the development of the
44 *Education Agenda*. This summary is not presented as a critique of past processes or decisions, but is
45 intended to highlight opportunities for future improvements. The EMS pioneers who established our
46 current EMS education process laid the foundation upon which future generations can build. However,
47 with the benefit of hindsight, opportunities for improvement are apparent.

1
2 **1950 to 1970**

3
4 **EMS Education Developments**

5 In the mid-50s, the American College of Surgeons (ACS) developed the first training program for
6 ambulance attendants. The American Academy of Orthopedic Surgeons (AAOS) also conducted courses
7 for ambulance service personnel culminating in 1967 with the first “Orange Textbook,” *Emergency Care*
8 *and Transportation of the Sick and Injured*, edited by Doctor Walter Hoyt. This document, and the text,
9 *Training of Ambulance Personnel and Others Responsible for Emergency Care of the Sick and Injured at*
10 *the Scene and During Transport*, developed by the National Academy of Sciences and National Research
11 Council (NAS/NRC), were the first national attempt to standardize EMS training (Becknell, 1997).

12
13 The NAS/NRC’s *Accidental Death and Disability: The Neglected Disease of Modern Society* suggested
14 that the quality of prehospital care was an important determinant of survival from sudden injury and
15 stimulated the development of federal funding through the Highway Safety Act of 1966. In 1969, the
16 Highway Safety Bureau, later to become the National Highway Traffic Safety Administration (NHTSA),
17 came into existence, and the development of a curriculum to standardize ambulance attendant training
18 (EMT-Ambulance) was begun by Dunlap and Associates under contract to NHTSA.

19
20 **Historic Issues Important to the EMS Education Agenda for the Future**

- 21 • The need for standards for EMS education was recognized during this period. In order to achieve
22 this goal, NHTSA funded the development of an NSC by a third-party contractor. This set the
23 precedent for the way EMS education would be standardized for the next three decades.
- 24
25 • The initial development of Emergency Medical Technician (EMT) textbooks and the NSC was the
26 result of the identification of both a problem (preventable deaths from highway trauma) and a
27 solution (standardized training for ambulance attendants). Although the data used to drive these
28 events may be crude by today’s standards, this was a clear attempt to use evidence to identify and
29 resolve the problem of inadequate prehospital emergency medical care (NAS/NRC, 1966).

30
31 **1970 to 1980**

32
33 **EMS Education Developments**

34 In 1971, the EMT-Ambulance NSC was delivered to NHTSA by Dunlap and Associates. This
35 NSC provided information on course planning and structure, objectives, detailed lesson plans, specific
36 content material, and suggested hours of instruction. In response to model legislation recommended by
37 NHTSA, many states adopted the NSC in either law or rules; the curriculum and the scope of practice
38 became intertwined.

39
40 The Emergency Medical Services Systems Act (P.L. 93-154), passed by Congress in 1973, provided
41 categorical grant funds for the establishment of regional EMS systems that embraced 15 key
42 components, including training and manpower. Training was thereby ensured a prominent place in EMS
43 system development.

44
45 Perceiving a need for a separate EMS training program for law enforcement officers, NHTSA developed
46 the 40-hour *Crash Injury Management for the Law Enforcement Officer* training program in the early
47 1970s. Subsequently, this evolved into the First Responder: NSC (1979).

48
49 The first Board of Directors meeting of the National Registry of Emergency Medical Technicians
50 (NREMT) took place in 1970. The purpose of the NREMT was to provide uniform standards for the
51 credentialing of ambulance attendants (NREMT, 1997).

1 In 1975, the American Medical Association (AMA) recognized the EMT-Paramedic as an allied health
2 occupation. The Essentials for EMT-Paramedic Program Accreditation were developed in 1976 and
3 adopted in 1978 by the AMA Council of Medical Education. The Joint Review Committee on Education
4 Programs for the EMT-Paramedic (JRCEMT-P) made the “Essentials” the standard for evaluating
5 programs seeking accreditation (JRCEMT-P, 1995). Although EMS education and allied health education
6 developed at approximately the same time, they frequently took divergent paths.

7
8 Primarily in response to developments in the early management of cardiac patients, the first EMT-
9 Paramedic NSC was developed by NHTSA in 1977 and included 15 modules of instruction.
10 Subsequently, the National Council of State EMS Training Coordinators, Inc. (NCSEMSTC), and the
11 NREMT developed an additional EMS level between the EMT-Ambulance and the EMT-Paramedic
12 levels of practice. This grew out of the perceived need to have certain emergency capabilities available to
13 victims even though they could not support a paramedic level service. Modules I, II, & III of the EMT-
14 Paramedic: NSC (Roles & Responsibilities, Human Systems: Patient Assessment, and Shock and Fluid
15 Therapy) plus the esophageal obturator airway and anti-shock trouser lessons were designated as the
16 EMT-Intermediate: NSC.

17
18 Increasingly, the NHTSA curricula became national standards for EMS education and continued to be
19 referenced in many state laws and administrative rules as the basis for scope of practice.

20 21 **Historic Issues Important to the EMS Education Agenda for the Future**

- 22 • During the early 1970s, there were few textbooks available and a small number of EMS experts.
23 The detailed NSC were essential to the uniform development of EMS education.
- 24
25 • Curricula become synonymous with scope of practice in many states.
- 26
27 • No national organization or federal agency had the responsibility and authority to create new levels
28 of EMS education and practice. In the absence of a master plan to guide this development,
29 decisions were made based on the perceived needs of different agencies, organizations, and states.
- 30
31 • Because each curriculum was developed independently of the others and by different contractors
32 using different processes, content and instructional methodology were inconsistent. It was
33 difficult, for instance, for a First Responder to bridge to an EMT-Ambulance or for an EMT-
34 Intermediate to bridge to an EMT-Paramedic. There was no national system of promulgating
35 EMS education and training standards and ensuring their compatibility.
- 36
37 • There was no systematic method for field providers, medical directors, state EMS officials or
38 others to participate in the development or revision process of NSC. The process for public input
39 varied from contractor to contractor, and in some instances, there was no input. It was difficult for
40 interested persons to know how decisions were made, who made them, and how persons other
41 than the contractor could have an opportunity to participate.
- 42
43 • Medical direction for education programs became a high priority. However, limited numbers of
44 physicians were available to assume this responsibility.

45 46 **1980 to 1990**

47 48 **EMS Education Developments**

49 In 1984 the NCSEMSTC, under contract to NHTSA, revised the EMT-Ambulance: NSC and increased
50 the number of hours from 81 to 110. There was little EMS system involvement in this revision
51 process. The EMT-Paramedic NSC revision was completed by NCSEMSTC and was reorganized into a 6
52 division/27 subdivision format. A stand-alone EMT-Intermediate NSC was also developed by the
53

1 NCSEMSTC. Common to most of these curricula were detailed instructor lesson plans, course guides,
2 and refresher courses.

3
4 In addition to an increase in the number of trained and certified EMS providers, there was an increase in
5 both the number and the quality of textbooks and educational support material referencing the NSC.

6 **Historic Issues Important to the *EMS Education Agenda for the Future***

- 7 • There was an increase in the quantity and quality of non-federal EMS educational support
8 materials. The NSC provided detailed instructor lesson plans and course guides emphasizing a
9 single method of organizing and conducting the EMS course of instruction.
- 10 • The process of making decisions about course length, levels, and format was still not clear. These
11 decisions varied, depending on the contractor and the current leadership at NHTSA. There was no
12 policy on how EMS providers or interested persons could provide input to the process.
- 13 • There was limited consistency in educational format, content, and patient care approach among
14 the various curricula. It was still not possible, for instance, to bridge from EMT-Ambulance to
15 EMT-Intermediate or EMT-Intermediate to EMT-Paramedic.

16 **1990-2000**

17 **EMS Education Developments**

18 Recognizing the need to look more comprehensively at the future of EMS education, NHTSA in
19 1990 convened the Consensus Workshop on Emergency Medical Services Training Programs. For the
20 first time, representatives of the EMS community discussed the national curricula needs of EMS
21 providers and identified the priority needs for EMS training. The priorities established at this consensus
22 meeting determined the national priorities for EMS education for the 1990s.

23 A formal national, multi-disciplinary consensus process was used to develop the *National EMS Education
24 and Practice Blueprint* in 1993. This was the first attempt to determine prospectively and systematically
25 the levels of EMS providers. The purpose of the *Blueprint* was to establish: 1) nationally recognized
26 levels of EMS providers; 2) nationally recognized scopes of practice; 3) a framework for future curriculum
27 development projects; and 4) a standardized pathway for states to deal with legal recognition and reciprocity. This
28 consensus process, involving initial peer review and subsequently a formal national consensus meeting moderated
29 by an independent facilitator, set the stage for future EMS consensus activities.

30
31 In 1994, Samaritan Health Services completed the *EMT-Basic: NSC* (renamed from EMT- Ambulance)
32 under contract to NHTSA. The curriculum, which remained at 110 hours by contract, changed the
33 emphasis of EMT-Basic education from diagnosis-based to assessment-based. “Nice to know”
34 information was treated with less emphasis and “need to know” information was stressed. Despite an
35 expert panel approach, the changes in the EMT-Basic curriculum generated considerable national
36 attention, discussion, and concern. Increasingly, there was recognition that the *method* of changing the
37 curriculum was as important as the *content*. The *1994 EMT-Basic: NSC* again provided detailed
38 declarative material for each section without formal instructor lesson plans.

39 In 1995, the *First Responder: NSC* was revised by the Center for Emergency Medicine of Western
40 Pennsylvania under contract to NHTSA. This curriculum also provided detailed declarative material
41 without formal instructor lesson plans.

42
43 The following year, the EMS community, as represented by numerous national organizations, adopted
44 the *EMS Agenda for the Future*. The document provided broad guidance for continuing development
45 of the EMS system along with a number of specific EMS education recommendations.

1
2 In 1996, NHTSA convened an EMS Education Conference with representatives of more than 30
3 EMS- related organizations to identify the next logical steps to implement the education section of the
4 *1996 Agenda*. The recommendations of this group eventually culminated in the preparation of this
5 document.

6
7 The proliferation of EMS textbooks and instructional materials continued. Alternative methods of EMS
8 education (e.g., Internet, CD-ROM, distance education) became more prominent.

9
10 In 1998, the *EMT-Intermediate* and *EMT-Paramedic NSC* were revised by the Center for Emergency
11 Medicine of Western Pennsylvania under contract to NHTSA. This revision utilized an expert panel and
12 modified the national consensus approach. Although the *NSC* were reasonably consistent with the
13 *Blueprint*, the emphasis on expanded skills and a more diagnosis-based approach to EMT-Paramedic
14 education contrasted with the recently revised *EMT-Basic NSC*. These issues generated considerable
15 national controversy. Most discussion centered around the scope of practice and the degree of declarative
16 information rather than on educational methodology. The close relationship between curriculum and
17 scope of practice issues made the resolution of challenges more difficult. Detailed content outlines were
18 still included

19 20 **Historic Issues Important to the EMS Education Agenda of the Future**

- 21 • Although there was more involvement on the part of providers, medical directors and state EMS
22 offices in determining the direction of EMS education through the 1990 training consensus
23 meeting and the *National EMS Education and Practice Blueprint*, there was still not a well-
24 defined infrastructure and system to guide future EMS education.
- 25
26 • In many states, the scope of practice was still driven by the *NSC*, thus politicizing and
27 complicating the writing of *NSC*.
- 28
29 • Although the *National EMS Education and Practice Blueprint* defined provider levels and their
30 requisite level of knowledge and skills, the overall purpose and philosophy of the document was
31 not well understood by many decision makers. Also, a systematic and well-defined method of
32 updating it did not exist.
- 33
34 • National standard curricula development was expensive, fraught with political and practical
35 difficulty, consumed enormous resources and energy, and frequently fragmented the national
36 EMS community.
- 37
38 • Quality education resources supplied by the private sector increased substantially by way of
39 textbooks, instructor lesson plans, CD-ROM, the Internet, distance education, and others. The
40 national standard curricula, however, continued to include declarative material that was
41 frequently used in place of instructor lesson plans.
- 42
43 • The *1996 Agenda* made a number of recommendations for the EMS education system of the
44 future. The recommendations included the development of core content to replace current
45 curricula, increased EMS education program academic affiliation, increased reliance on an
46 accreditation process, additional flexibility for local programs while ensuring minimum entry
47 level competencies, and an improved ability to bridge from one education level to another.
- 48
49 • Leaders of national EMS organizations representing EMS administrators, physicians, regulators,
50 educators, and providers met at a NHTSA-sponsored EMS education meeting and specified that
51 EMS needed a cyclic process for curriculum revision that embraced all provider levels and
52 enhanced flexibility, yet promoted national consistency.
- 53

- The *Education Agenda* task force initiated the development of this document.

Opportunities for Improvement

Over the past thirty years, considerable progress has been made in EMS education. ~~As we enter the next millennium, public~~ Public expectations, ~~patient needs~~ and changes in health care delivery are ~~continuing to create~~ new opportunities for EMS. This document, the *EMS Education Agenda for the Future: A Systems Approach*, ~~represents an approach~~ that will enable EMS to evolve and advance ~~over time during this unique period in history.~~

Since the release of the *Education Agenda* in 2000, the EMS community has worked collaboratively to identify and implement strategies that support an effective educational model consistent with other health professions.

Following are a number of specific opportunities for improvement that were addressed by the *Education Agenda*, together with a review of the current status of such strategies.

- **Current limitation:** There is not an established national EMS education system or master plan.

Proposed solution: The *Education Agenda* proposes a system consisting of the following five components:

- ✓ National EMS Core Content
- ✓ National EMS Scope of Practice Model
- ✓ National EMS Education Standards
- ✓ National EMS Education Program Accreditation
- ✓ National EMS Certification

The role of each component is clearly delineated, the participants identified, the process for participation established, the decision-making process defined, and the relationship among components specified. ~~Each component is flexible enough to allow timely educational advances.~~

2015 Status: ~~The *Education Agenda* was developed using a national consensus process and completed in 2000.~~

- **Current limitation:** The overall domain of EMS knowledge and skills is not defined. Each time curricula are developed, this issue is revisited, causing extensive discussion and considerable frustration.

Proposed solution: Develop a ~~National EMS~~ *Core Content* describing the entire domain of out-of-hospital emergency medical care. Establish a schedule and method for updating the ~~National EMS~~ *Core Content*. A ~~National EMS~~ *Core Content* obviates the need to revisit the medical appropriateness of each procedure or cognitive domain when standards are revised. With this essential framework, the architects of the other system components can focus on their specific area of responsibility, rather than on defining and redefining the overall domain of practice.

2015 Status: NHTSA and HRSA published the *Core Content* in 2005.

- **Current limitation:** *NSC* drives the scope of practice for EMS providers.

Proposed solution: Scope of practice should drive national education standards. Revise the *Blueprint* and rename it the *National EMS Scope of Practice Model*. The ~~National EMS~~ *Scope of Practice Model* will define, by name and by function, the levels of out of hospital EMS providers

1 based upon the **National EMS Core Content**. The **National EMS Scope of Practice Model**, rather
2 than the curricula, will drive the scope of practice and national provider level nomenclature and
3 establish the entry level competencies. With the scope of practice no longer determined by the
4 curricula or the **National EMS Education Standards**, there will be considerable flexibility in
5 designing EMS education programs.
6

7 With an established schedule and method for updating the **National EMS Scope of Practice**
8 **Model**, state-established scopes of practice can be regularly and consistently updated and will
9 keep pace with EMS practice analysis and EMS research. Medical directors, EMS providers, state
10 officials, and others will know precisely how and when they can provide input to the *Blueprint*.
11

12 **2015 Status:** NHTSA published the *Scope of Practice* in 2007. According to the NASEMSO
13 Implementation Survey published on April 23, 2014, 100% of states intend to use the *Scope of*
14 *Practice* as foundation for state licensure at both the EMT and Paramedic level.
15

- 16 • **Current limitation:** The **EMS NSC**, with their detailed declarative material, limits instructor
17 flexibility and the ability to adapt to local needs and resources. Because of reliance on highly
18 prescriptive ~~national standard curricula~~ NSC, many programs and instructors have never
19 developed their own curricula or instructional materials. In general, EMS faculty have little
20 experience in evaluating and using the vast array of instructional materials that are available
21 from educational publishers.
22

23 **Proposed solution:** The **National EMS Education Standards** will define terminal learning
24 objectives for each level of EMS provider. They will be regularly updated. These standards will
25 serve as the basis for detailed declarative instructional materials and instructor lesson plans to be
26 developed by instructors, educational institutions, publishers, and others.
27

28 Rather than having ~~national standard curricula~~ NSC which define one national method of
29 instruction, a greater variety of lesson plans will be available from vendors of educational
30 materials and from educational institutions. The **National EMS Education Standards** will
31 encourage enhanced flexibility for the instructor, allowing multiple instructional methods while
32 maintaining consistency of learning objectives.
33

34 **2015 Status:** NHTSA published the *Education Standards* in 2009. According to information
35 gathered by NASEMSO in 2013, 29% of states list instructor or educator preparedness to use the
36 *Education Standards* as a barrier to implementation of the *Education Agenda*.
37

- 38 • **Current limitation:** The quality of EMS education varies throughout the nation. Adherence to
39 the NSC in and by itself does not ensure quality.
40

41 **Proposed solution:** Develop **National EMS Education Standards** along with a program of
42 accreditation and national certification. Consistent **National EMS Education Standards**, combined
43 with national accreditation of EMS programs and national certification, will provide greater
44 assurance of the quality and consistency of both the *process* and *outcome* of EMS education.
45

46 **2015 Status:** NHTSA published the *Education Standards* in 2009 together with *Instructor*
47 *Guidelines* to facilitate the transition from the NSC to the *Education Standards*. National
48 accreditation and certification have been adopted by increasing numbers of political jurisdictions
49 to assure the quality and consistency of both the process and outcome of EMS education.
50

- 51 • **Current limitation:** The appropriate disciplines do not have the appropriate responsibilities in
52 the current EMS education process. Physicians and regulators make educational decisions,
53 educators and regulators make medical decisions, and physicians and educators make regulatory

1 decisions.

2
3 **Proposed solution:** The proposed system will align the primary responsibilities appropriately
4 with the content experts while recognizing that the entire system is a fully cooperative effort.
5 ~~National EMS Core Content~~ is developed by physicians with input from regulators, educators,
6 and providers. ~~National EMS Scope of Practice Model~~ is developed by regulators with input from
7 physicians, educators, and providers. ~~National EMS Education Standards~~ are developed by
8 educators with input from physicians, regulators, administrators, and providers.

9
10 **2015 Status:** The first cycle of the proposed system was fully realized with the publication of
11 the *Education Standards* in 2009.

- 12
13 • **Current limitation:** It is not clear who ultimately makes decisions about the education
14 components, or how one has input or participates in the decision-making process.

15
16 **Proposed solution:** The *EMS Education Agenda for the Future* clearly delineates who is
17 responsible for each component, how input is provided, how decisions are made, and when the
18 components are updated.

19
20 **2015 Status:** Development of the *Core Content*, *Scope of Practice*, and *Education Standards*
21 were each led by the EMS stakeholder group specified in the *Education Agenda*.

- 22
23 • **Current limitation:** The names of EMS provider levels vary considerably from state to state.

24
25 **Proposed solution:** Providing regulators with the primary responsibility for establishing the
26 ~~National EMS Scope of Practice Model~~ and clearly defining the levels should facilitate greater
27 consistency of provider levels across political jurisdictions. When this is combined with national
28 certification and program accreditation, there will be considerable incentive for standardization of
29 provider levels.

30
31 **2015 Status:** There is less variability in EMS provider levels across political jurisdictions than
32 before publication of the *Education Agenda*.

- 33
34 • **Current limitation:** EMS provider licensure standards vary considerably from state to state.

35
36 **Proposed solution:** Establishing uniform ~~National EMS Education~~ Program Accreditation
37 combined with ~~National~~ EMS Certification will reduce variability in licensure standards.

38
39 **2015 Status:** More political jurisdictions have adopted program accreditation and provider
40 certification than before publication of the *Education Agenda*.

- 41
42 • **Current limitation:** EMS educational program standards and the processes for obtaining state
43 approval to conduct EMS education vary considerably.

44
45 **Proposed solution:** Consistent program accreditation standards, including realistic methods for
46 full-service accreditation, will significantly reduce this variability.

47
48 **2015 Status:** More political jurisdictions have adopted program accreditation and provider
49 certification than before publication of the *Education Agenda*.

- 50
51 • **Current limitation:** EMS education is based on perceived needs rather than practice analysis
52 and research.

1 **Proposed solution:** A regular feedback loop connecting the core content, practice analysis, and
2 research efforts will gradually improve the empirical basis of EMS education.
3

4 **2015 Status:** It is anticipated that up to date practice analysis and evidence based research will
5 inform the next major revision cycle of the *Education Agenda*.
6

- 7 • **Current limitation:** The locus of control for EMS education is placed within government, not
8 the educational facility, program, and faculty.
9

10 **Proposed solution:** The EMS education system of the future will facilitate appropriate roles for
11 government and educational facilities. This will provide significantly greater flexibility for
12 educational institutions and programs while still ensuring reasonable national standards.
13

14 **2015 Status:** Realization of the first cycle of the proposed system resulted in identification of
15 appropriate roles for government and educational facilities.
16

- 17 • **Current limitation:** The content of *NSC* is perceived to be determined by the federal contractor.
18

19 **Proposed solution:** Establishing an EMS education *system* will provide for a balanced approach
20 to EMS education and reduce the perception of a disproportionate influence by any single
21 participant. The establishment of specific responsibilities, combined with the interrelationship of
22 system components, will provide reasonable checks and balances.
23

24 **2015 Status:** Realization of the first cycle of the proposed system resulted in the balanced
25 approach to EMS education achieved by separation of responsibilities among EMS physicians,
26 EMS regulators, and EMS educators as envisioned by the authors of the *Education Agenda*.
27

- 28 • **Current limitation:** The *NSC* are in various formats and frequently are not consistent with each
29 other. This reduces the ability to “bridge” from one level to another.
30

31 **Proposed solution:** Replacing the ~~national standard curricula~~ *NSC* with ~~National EMS~~ *Education*
32 *Standards* will eliminate this problem. Guided by the ~~National EMS~~ *Core Content* and consistent
33 with the ~~National EMS~~ *Scope of Practice Model*, the ~~National EMS~~ *Education Standards* will
34 ensure reasonable uniformity while providing flexibility in approach and educational format.
35

36 **2015 Status:** Development of *Education Standards* and *Instructor Guidelines* has assured both
37 consistency with scope of practice and flexibility in educational approach and format.
38

- 39 • **Current limitation:** The *NSC* are frequently out of date.
40

41 **Proposed solution:** Because of the time and expense involved in writing *NSC*, it is difficult to
42 perform frequent revisions. In the EMS education system of the future, the ~~National EMS~~ *Core*
43 *Content* and ~~National EMS~~ *Scope of Practice Model* will be periodically updated based upon new
44 information and research. The ~~National EMS~~ *Education Standards* can then be revised more
45 frequently. Publishers can update their books and their instructor lesson plans as frequently as the
46 market demands. Instructors will have current information available to them.
47

48 **2015 Status:** Textbooks and instructor lesson plans are now being incrementally revised as
49 evidence based research emerges as a basis for ongoing evolution of EMS practice.
50

- 51 • **Current limitation:** The *NSC* development process is very expensive and frequently fragments
52 the community.
53

1 **Proposed solution:** Revising the **National EMS Scope of Practice Model** and the **National EMS**
2 Education Standards will be less expensive and time-consuming. Because there will be a
3 standardized method of updating them and the decision-making process will be less contentious,
4 there will be greater cooperation in the EMS community. Instructors will be free to choose
5 instructional support materials and there will be competition among publishers to produce high-
6 quality products.

7
8 **2015 Status:** It is anticipated that the next major revision cycle of the *Education Agenda* will be
9 considerably less contentious and expensive than periodic revisions of the *NSC* were in the past.

- 10
11 • **Current limitation:** Most state-authored EMS licensure examinations do not follow the
12 accepted methodology for verifying entry level competency.

13
14 **Proposed solution:** **National** EMS Certification will be based upon an up-to-date practice
15 analysis and will follow accepted psychometric methodology for identifying entry level
16 competency.

17
18 **2015 Status:** More political jurisdictions have adopted EMS Certification methods that are
19 consistent with those proposed in the *Education Agenda*.

- 20
21 • **Current limitation:** The EMS educational process has developed separately from the formal
22 post-secondary education system. This has frequently precluded EMS personnel desiring to obtain
23 academic credit from doing so. This impedes EMS personnel from pursuing higher education,
24 which would ultimately further the EMS profession.

25
26 **Proposed Solution:** The EMS education system of the future is compatible with an academically
27 based approach to EMS education and more closely parallels the developments in other allied
28 health education. The system will also support alternative methods of educating EMS providers
29 and promote innovative relationships between academic and non-academic programs.

30
31 **2015 Status:** The EMS education system of the present is more compatible with an academically
32 based approach to EMS education than before publication of the *Education Agenda*.

33 34 **Attributes of the EMS Education System of the Future**

35
36 The EMS education system of the future has these attributes:

- 37
38 • The EMS education system is national in scope while allowing for reasonable state and local
39 flexibility;
- 40
41 • The EMS education system is guided by patient care needs and is educationally sound and politically
42 feasible;
- 43
44 • The components of the EMS education system are clearly articulated, with a lucid definition of their
45 interrelationships;
- 46
47 • The responsibility and time frames for updating each of the system components are clearly
48 delineated;
- 49
50 • The method for providing input and participating in the outcome of each component is clearly defined
51 with an established role for providers, administrators, physicians, regulators, educators, and others;
- 52

- 1 • The ongoing system evolution is guided by scientific and educational research and the principles of
2 quality improvement;
3
- 4 • The EMS education system is stable enough and strong enough to outlive its architects and exist
5 independently of the current leadership of any national EMS stakeholder organization;
6
- 7 • Physicians are primarily responsible for determining the medical content; regulators the regulatory
8 issues; and, educators the educational issues;
9
- 10 • The EMS education system supports multiple instructional methodologies; and
- 11
- 12 • The *Education Agenda* is intended to promote quality and consistency among EMS education programs and
13 establish common entry-level requirements for the licensure of various levels of EMS personnel throughout
14 the nation; but it is recognized that each State ultimately retains the authority to regulate EMS education
15 within its borders.
16

17 Assumptions

18
19 Implicit within this document and underlying the proposed EMS education system design are the
20 following assumptions:
21

- 22 • The *Education Agenda* describes the framework of the EMS education system and defines the
23 primary responsibilities for constructing each component. However, it does not describe in great
24 detail the specific elements of its individual components. This should be done by the appropriate
25 content experts in their respective areas.
26
- 27 • The EMS profession will benefit from a well-organized EMS education system.
28
- 29 • The federal government can play a leadership role in facilitating the design and implementation of an
30 EMS education system.
31
- 32 • NHTSA, in concert with the Health Resources and Services Administration (HRSA) and other federal
33 agencies, will continue to be the federal agency primarily responsible for coordinating the EMS
34 education system and for further defining the responsibilities of each system component.
35
- 36 • A *system* of EMS education should promote reasonable national education and licensure consistency
37 while providing for unique local variations is in the best interest of patient care.
38
- 39 • Widespread EMS provider licensure reciprocity among states is a worthy goal.
40
- 41 • An EMS education *system* should be inclusive, establishing reasonable performance expectations and
42 consistency while allowing multiple instructional methodologies to be used as long as they produce a
43 consistently high-quality end product.
44
- 45 • An appropriately designed EMS education *system*, operating on the principles of quality
46 improvement, should be able to assess its own performance, alter its methods, and modify, if
47 required, its very design.
48
- 49 • Ongoing EMS research and data should drive, in a systematic fashion, the individual components of
50 the EMS education system.
51
- 52 • As stated in the *1996 Agenda*, the EMS education system should embrace the expectations and

1 components of the EMS community. The components must be updated often enough to meet the
2 needs of EMS patients and provide an infrastructure which supports innovative solutions addressing
3 cultural variation, rural circumstances, increasing variability in EMS practice venues, and travel and
4 time constraints.
5

- 6 • Publishers and other interested parties will continue to produce high-quality, up-to-date EMS
7 instructional materials, including detailed instructor lesson plans which are consistent with the
8 ~~National EMS~~ *Education Standards* while allowing for creativity and innovation.
9
- 10 • As the *Education Agenda* evolves, the preparation of EMS instructors will continue to improve. All
11 EMS instructors will receive formal training in educational theory and practice, curriculum design
12 and development, instructional materials design, evaluation, and use. Ensuring appropriate academic
13 preparation of EMS instructors will be a responsibility that must be shared by NHTSA, state EMS
14 offices, and EMS education programs sponsors.
15
- 16 • The newly designed EMS education system will be able to respond to constant evolution of EMS,
17 including the challenges of implementing the *1996 Agenda*.
18
- 19 • The *Education Agenda* addresses only the initial education of EMS providers. It does not address
20 continued education or continued competency assurance. It is assumed that the EMS community will
21 establish a process that will address a comprehensive systems approach to both.

NATIONAL EMS EDUCATION SYSTEM

Today's EMS education system is going through dramatic and profound changes. In response to extraordinary technological advancements and changes in societal expectations, education is expected to emphasize high-level cognition, problem solving, and the ability to deal with ambiguity and conflicting priorities. The public and employers expect graduates to be competent in a wide range of practical skills and have the ability to adapt to an ever-changing and complex environment.

The public and employers demand that health care education produce graduates who are responsive to the needs of the patient, have excellent communication skills, and are able to adapt to changes in their responsibilities. They demand graduates who are technically competent, socially conscious, and culturally sensitive. In addition to their traditional role as emergency care providers, EMS providers will need to be able to identify and modify illness and injury risks, provide acute illness and injury care and follow-up, and contribute to the treatment of chronic conditions and community health monitoring.

The changing expectations of EMS and health care education necessitate a clearly defined and responsive education *system* with the attributes enumerated in this document.

The EMS treatment guidelines and EMS educational curricula of the future should be evidence based and data driven. EMS should provide care that is directed by this continually evolving knowledge base.

The NASEMSO 2011 EMS Industry Snapshot indicates the majority of EMS Educational Programs in the United States are most commonly located within the State community college system or through local non college-based programs maintained within EMS agencies (Federal Interagency Committee on Emergency Medical Services, 2011).

Thirty-nine (78%) States have both a certificate and formal college degree program within their State. These States allow EMS professionals to choose between a certificate and degree based program. It is noted that 10 (20%) of the States do not have formal EMS educational programs resulting in a college degree.

New System Components

This document defines the infrastructure of an EMS education system which will promote national uniformity while being responsive to local needs. It will be driven by research while recognizing the need for reasonable consistency and stability. This document also articulates the responsibilities of the individuals or agencies responsible for each component of the system. Each section identifies a system component and analyzes it in **five** ways:

- Where we **were in 2000**;
- Where we wanted to be in 2010;
- How **we wanted** to get there;
- **Where we are in 2015**; and,
- **Minimal Updates based on Current Evidence**

Particular emphasis is placed on the interrelationships of the five components outlined in the previous sections and how they are mutually supportive. Consideration of individual components must include the interrelationship with the other components. The reader should strive to take a systematic view and is cautioned against judging the individual components before considering how they affect and relate to each of the other components.

1
2 Appendix A is a graphical representation of the components and their interrelationships. It demonstrates
3 the dependent relationship each component has with the others. The supportive components (practice
4 analysis, EMS research, past experience, and the *1996 Agenda*) are found across the top of the diagram.
5

- 6 • The supportive components guide the development of the **National EMS Core Content**,
7 which represents the entire domain of out-of-hospital knowledge and skills.
8
- 9 • The **National EMS Core Content** drives the **National EMS Scope of Practice Model**,
10 which names and defines the **consensus** national levels of EMS practice.
11
- 12 • The terminal knowledge and skill objectives for each level of practice identified in the
13 **National EMS Scope of Practice Model** is defined by the **National EMS Education**
14 **Standards**.
15
- 16 • The **National EMS Education Standards** are also a part of the **National EMS Education**
17 **Program Accreditation** requirements and are a resource in the development of
18 instructional support materials and instructor development programs.
19
- 20 • **National EMS Education** Program Accreditation helps to ensure the ongoing quality and
21 consistency of EMS instruction.
22
- 23 • Graduation from an accredited program is required to participate in **National EMS**
24 **Certification**, which is based on the levels defined by the **National EMS Scope of Practice**
25 **Model**. In addition to the **National EMS Education Standards**, the practice analysis guides
26 the development of **National EMS Certification**. **National EMS Certification** is one
27 requirement for state licensing of EMS professionals.
28

29 The entire process follows a continuous quality improvement model, with review and revisions at regularly
30 scheduled intervals. The EMS education system is defined by a continuum ranging from **National EMS**
31 **Core Content** through **National EMS Certification**. ~~National EMS Core Content is revised least frequently~~
32 ~~while National EMS Certification is revised most frequently~~. Revision of **National EMS Core Content** may
33 necessitate a revision of every other component. During the revision of each EMS education system
34 component, interested parties may find out exactly how and when they may provide input and participate
35 in the process. The decision makers are clearly defined.
36

37 In addition, the system is designed to respond to major changes immediately, if needed. Since the **National**
38 **EMS Education Standards** reference terminal objectives, most classroom and program educational changes
39 will occur at the local level. If a major change is needed nationally, it will be made at the level deemed
40 appropriate by system review.
41

42 EMS faces many unique local and regional challenges. In 2000, the ~~current~~ EMS education process
43 reflected a potpourri of solutions to these problems. Additionally, the educational approach, career needs,
44 and professional expectations ~~were~~ not consistent among the various levels of current provider (First
45 Responder, EMT-Basic, EMT-Intermediate, and EMT-Paramedic). ~~Clearly, Even so,~~ a rigid and
46 prescriptive system will not meet the needs of all constituents. Any education system for the future must
47 **continue to** be flexible enough to meet the needs of the diverse communities that it serves.
48

49 This document draws on the experience of EMS and other allied health professions to propose an
50 education system consistent with this vision and its stated attributes. It allows for continued and
51 systematic growth of the EMS education system and will assist EMS leaders in making informed
52 decisions about their future.

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The Role of Continuing Education in Continued Competency Assurance

Following initial certification of entry level competence, an EMS provider may become incompetent due to his or her failure to keep up with constant changes in the art and science of medicine. Technical and professional persons are at significant risk of becoming outdated in their skills and their knowledge. It is not enough for them to maintain the competence acquired in the years of formal education. In the profession, information is not static; perpetual change is the norm (Dubin, 1977).

Continuing education is only one part of continued competency assurance. In turn, continued competency assurance is only one component of a quality assurance program. A well-designed continued competency assurance program includes performance and outcome indicators which correlate to the practice analysis and scope of practice. EMS continuing education and continued competency assurance are integral parts of a comprehensive educational system, but are not addressed in this document. **A similar systems approach to continuing education and continued competency assurance in EMS should be developed.**

The public expects EMS personnel to provide safe, effective, efficient, and culturally competent patient care of the highest achievable quality during a variety of environmental and situational conditions regardless of the time of day or day of the week. EMS personnel must maintain a high degree of cognitive and psychomotor competency as well as accurate and rapid clinical decision-making and judgment. Continuing education programs, either as independent enterprises or part of the infrastructure of the EMS agency must focus on delivering evidence- and competency-based continuing education in order to safeguard both the EMS personnel and the public. State agencies should promote competency-based rather than hours-based continuing education requirements.

1

2 NATIONAL EMS CORE CONTENT

3
4
5

6 Core content is used in some physician education programs to define the scope of a specialty
7 discipline, develop residency training programs, and identify material for board examinations. Core
8 content has been very useful in achieving these objectives, and can be used for similar purposes in
9 emergency medical services.

10
11 ~~National EMS~~ *Core Content*, will define the entire domain of out-of-hospital EMS education, and will
12 serve as the broad base for the rest of the EMS education system. It will address knowledge content
13 globally so that state-of-the-art changes and regional practice patterns can be reflected within its broad
14 framework. It will be medically directed, based upon research and the practice analysis, and periodically
15 revised.

16 **Where We Were in 2000**

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18
19 ~~Currently~~In 2000, there ~~was is~~ no national EMS core content, or any document that serves the purpose of
20 defining the entire domain of out-of-hospital medicine. The *Blueprint*, created in 1993 by a multi-
21 disciplinary group of EMS leaders, generally defines the domain of the prehospital EMS profession, but
22 this ~~was is~~ intermingled with definitions of EMS provider levels which delineated scope of practice. The
23 *Blueprint* broke new ground by introducing uniformity in the definition of provider levels without
24 dependency on a specific version of a curriculum. The validity and utility of the *Blueprint* could be
25 enhanced by separating the development of the core content from the provider level designation. This
26 would allow leadership for the development of each document to be assumed by the most appropriate
27 group.

28 **Where We Wanted To Be in 2010**

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31 The ~~National EMS~~ *Core Content* ~~was to will~~ present the broad domain of knowledge and skills which
32 encompass the out-of-hospital EMS disciplines by identifying the general practices of EMS providers
33 without reference to discrete provider levels. The ~~National EMS~~ *Core Content* document ~~was to will~~ be
34 authored primarily by the EMS medical community, with input from EMS regulators, EMS educators, and
35 EMS providers. The EMS medical community ~~was to will~~ be ~~comprised of~~ physicians who have direct
36 involvement in EMS. NHTSA ~~was will be~~ responsible for overseeing the process.

37
38 The *1996 Agenda* ~~was to will~~ remain the guiding document setting the vision for EMS. It ~~will was to~~ be
39 reviewed and updated periodically, under NHTSA leadership. The ~~National EMS~~ *Core Content* ~~was to~~
40 ~~will~~ be created and revised by utilizing the *1996 Agenda*, practice analysis, EMS-related research, and
41 the body of knowledge created by practical experience. The ~~National EMS~~ *Core Content* ~~was to will~~ be
42 updated at regular intervals -- every 5 to 7 years, or more frequently as needed -- to reflect current
43 developments in EMS practice, clinical advances, and education.

44
45 A practice analysis ~~was to will~~ be conducted for each nationally recognized EMS level by the national
46 certification agency and ~~was to will~~ help to identify the practices of currently functioning EMS
47 providers. The practice analysis ~~was to will~~ be national in scope and ~~was to will~~ follow sound qualitative
48 and quantitative methodology. The practice analysis ~~was to will~~ be updated at least every 5 years. It will
49 be one of several pieces of information used in revising the ~~National EMS~~ *Core Content*.

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How We Wanted To Get There

The ~~National EMS Core Content~~ was to ~~will~~ be the result of a consensus process, led by a group consisting of physicians with direct involvement in EMS, with input from EMS regulators, EMS educators, and EMS providers. The drafts ~~were to will~~ be extensively peer and community reviewed.

The ~~National EMS Core Content~~ was to ~~will~~ be developed by using input from a number of sources. The *1996 Agenda* and a needs assessment ~~was to will~~ provide a vision for the direction of EMS. A formal practice analysis and EMS research ~~was to will~~ provide the authors of the *Core Content* with information about the current practices of EMS. Finally, the *Core Content* ~~was to will~~ be based on the foundation of past experience.

NHTSA ~~should~~ assumed the leadership role for the development, implementation, and distribution of the ~~National EMS Core Content~~. This document, once completed, will serve as the domain of practice from which the ~~National EMS Scope of Practice Model~~ will be derived.

Where We Are in 2015

The *Core Content* was completed in 2005 and continues to define the domain of EMS practice.

Minimal Updates based on Current Evidence

The *Core Content* may need to be revised to remain up to date with current medical practice and science. EMS physicians will lead the revision process with input from the rest of the EMS community.

The following milestones are provided as illustrative steps that are likely to be taken but are not intended to imply a specific sequence or order.

Milestones	Organizations/ Resources Involved
Market the EMS Education Agenda for the Future to the EMS community and EMS organizations	EMS Education Task Force
Fund EMS educational improvement projects	Private, federal, state, and local Governments
Conduct a practice analysis of all nationally identified EMS provider levels	National certification agency
Develop National EMS Core Content based on practice analysis, <i>1996 Agenda</i> , research, and past experience.	NHTSA, EMS medical community, EMS regulators, EMS educators, and EMS providers

NATIONAL EMS SCOPE OF PRACTICE MODEL

Few, if any, other allied health professions have a document similar to the ~~current~~ 1993 *Blueprint* or the ~~proposed National EMS Scope of Practice Model~~. The diversity of EMS and the multiple levels of practice within EMS necessitate the discrete division in the scope of practice among these levels. The ~~National EMS Scope of Practice Model~~ defines the national levels of EMS providers including their entry level skills and knowledge.

Where We ~~Were~~ in 2000

In 1993, the *Blueprint* was developed through a national consensus process. This document established uniform definitions of EMS provider levels, including their entry level knowledge and skills. Based on the assumption that EMS knowledge and skills are on a continuum, it was designed to encourage “bridging” from one level to another, to facilitate reciprocity, to be the basis for national curriculum development, and to assist states in defining scopes of practice.

While the *Blueprint* received wide approval and acceptance in concept, it ~~was has been~~ inconsistently applied in practice. Moreover, curriculum developers felt it lacked the specificity to adequately guide curricular change.

Many states ~~have did~~ not changed their ~~current~~ provider levels to comply with the *Blueprint*, and many state laws and regulations continue to refer to the national standard curricula when defining EMS provider scope of practice. While the concept of the *Blueprint* ~~was is~~ solid, it ~~became has become~~ apparent that a single document ~~could not cannot~~ adequately address all of these issues. Since its development in 1993, the *Blueprint* has not been revised, ~~but played a key role in setting the stage for development of the Scope of Practice~~.

Where We ~~Wanted~~ to be in 2010

The *Blueprint* ~~was to will~~ be revised based upon the ~~National EMS Core Content~~ and re-titled the *National EMS Scope of Practice Model*. Because the *Scope of Practice Model* will define levels of practice which will be recognized in state laws and administrative rules, the revision ~~was to will~~ be authored and directed primarily by EMS regulators with input from the EMS medical community, EMS educators, and EMS providers. The *Scope of Practice Model* will define the nationally recognized levels of EMS providers and will identify their minimum entry level knowledge and skills. The ~~National EMS Scope of Practice Model~~ will be used by each state to determine scope of practice and to facilitate reciprocity.

How We ~~Wanted~~ To Get There

The ~~National EMS Core Content~~ ~~was to will~~ provide the foundation for the revision of the *Blueprint*. This revision will be renamed the *National EMS Scope of Practice Model*. The revision ~~was to will~~ be a consensus process led by a group of EMS regulators responsible for certifying and licensing EMS providers, with input from the EMS medical community, EMS educators, and EMS providers. The drafts ~~were to will~~ be extensively peer and community reviewed.

NHTSA ~~should~~ assumed the leadership for the revision, implementation, and distribution of the ~~National-EMS Scope of Practice Model~~. This document, once completed, guides the development of the ~~National-EMS Education Standards~~ and defines uniform levels of licensure in each state. Licensure is the legal authority to practice granted by a state agency.

Where We Are in 2015

NHTSA published the *National EMS Scope of Practice Model* in 2007. According to information gathered by the NASEMSO in 2013 and presented to the NEMSAC on April 23, 2014:

- 76% of states intend to use the *Scope of Practice* as foundation for state licensure at the EMR level (an increase of 18% since 2007)
- 100% of states intend to use the *Scope of Practice* as foundation for state licensure at the EMT level (an increase of 22% since 2007)
- 88% of states intend to use the *Scope of Practice* as foundation for state licensure at the AEMT level (an increase of 30% since 2007)
- 100% of states intend to use the *Scope of Practice* as foundation for state licensure at the Paramedic level (an increase of 24% since 2007)

Minimal Updates based on Current Evidence

The *Scope of Practice* must be revised on a periodic basis to remain up to date with medical practice and science. State EMS regulators will lead the revision process with input from the rest of the EMS community.

The following milestones are provided as illustrative steps that are likely to be taken but are not intended to imply a specific sequence or order.

Milestones	Organizations/Resources Involved
Market the EMS Education Agenda for the Future to the EMS community and EMS organizations	EMS Education Task Force
Fund EMS educational improvement projects	Private, federal, state, and local governments
Develop National-EMS Core Content based on practice analysis, EMS Agenda for the Future , research, and experience.	NHTSA, EMS medical community, EMS regulators, EMS educators, EMS providers
Revise the <i>Blueprint</i> and rename it National-EMS Scope of Practice Model	NHTSA, EMS medical community, EMS regulators, EMS educators, EMS providers
Communicate to states the need to transfer reliance on the NSC to the National-EMS Scope of Practice Model	NHTSA, NASEMSD, NCSEMSTC

NATIONAL EMS EDUCATION STANDARDS

Education standards are needed to guide program managers and instructors in making appropriate decisions about what material to cover in classroom instruction. Additionally, these standards are used as one component of program evaluation in the accreditation process and are used by publishers to develop instructional materials. In most allied health professions, education standards are developed by professional associations with broad community input. The complexity, interdisciplinary nature, and state government oversight of EMS necessitates a slightly different approach.

Where We Were in 2000

~~Currently~~ In 2000, the content of most EMS education programs ~~is~~ ~~was~~ based on a national standard curriculum (*NSC*). The *NSC* ~~were~~ ~~are~~ funded, developed, and updated periodically by the National Highway Traffic Safety Administration (NHTSA). *NSC* ~~were~~ ~~have been~~ developed for all nationally recognized levels of EMS education and consisted of detailed, highly prescriptive objectives and declarative material. Since these documents ~~were~~ ~~are~~ closely tied to scope of practice and because their revision ~~was~~ ~~is~~ the only national venue for the discussion of scope of practice, the *NSC* revision process ~~was~~ ~~is~~ time-consuming and expensive.

Many EMS education programs and faculty strictly followed the *NSC* in defining the content of their courses. A typical measure of quality for EMS programs ~~was~~ ~~has been~~ their adherence to the ~~current~~ *NSC*. Although the use of the *NSC* ~~has~~ contributed to the standardization of EMS education, the quality and length of programs ~~varied~~ ~~still vary~~ nationally. The reliance on the *NSC* has decreased flexibility, limited creativity, and made the development of alternative delivery methods difficult. The strict focus on the *NSC* may result in the development of narrow technical and conceptual skills without consideration for the broad range of professional competencies expected of today's entry level EMS providers.

Where We Wanted To Be in 2010

The ~~National EMS Education Standards~~ ~~were to will~~ be derived from the ~~National EMS Scope of Practice Model~~. Each ~~National EMS Education Standards~~ document ~~was to will~~ provide the minimal terminal objectives necessary for successful program completion of a level of EMS provider identified in the ~~National EMS Scope of Practice Model~~. All programs ~~were to must~~ adhere to these standards, but there ~~was to will~~ be significant flexibility in how to achieve the standards. The standards ~~were to will~~ be designed to encourage creativity in delivery methods such as problem-based learning, computer-aided instruction, distance learning, programmed self-instruction and others. Without the constraint of an unduly prescriptive *NSC*, EMS educational institutions are held more accountable for the content and quality of their instruction. This would require institutions to, at a minimum, conduct evaluations of both educational process and outcome quality.

With less prescriptive curriculum standards, it ~~was anticipated to will~~ be much easier to modify curriculum content, both locally and nationally. Changes based on research, practice analysis, future direction of the profession, and experience ~~were anticipated to be are~~ quickly reflected in education content, and these changes ~~were to be are~~ communicated to programs through a variety of mechanisms. While all programs ~~were to must~~ meet national standards, they ~~were to will~~ be encouraged to continually improve and excel.

1
2 There ~~were to will~~ be a variety of outstanding instructional materials including instructor lesson plans
3 available from publishers, educational institutions, and other interested parties to support local EMS
4 instruction. EMS instructors ~~were to will~~ utilize published materials or develop their own for classroom
5 use.

6
7 The scope of practice for EMS providers ~~was not to will~~ be defined by education standards or curriculum.
8 ~~National EMS Education Standards were to will~~ be designed to prepare EMS providers who are competent
9 to perform within a specific scope of practice. Education ~~was to will~~ support, rather than define, scope of
10 practice. The scope of practice for EMS providers ~~was to will~~ be based on the ~~National EMS Scope of~~
11 ~~Practice Model~~.

12 13 **How We Wanted To Get There**

14
15 The ~~National EMS Education Standards were to will~~ be developed by a group of EMS educators, with
16 input from EMS providers, the EMS medical community, and EMS regulators. The drafts ~~were to will~~ be
17 extensively peer and community reviewed. ~~National EMS Education Standards should were to be~~
18 developed for and based upon each level of EMS provider specified in the ~~National EMS Scope of~~
19 ~~Practice Model~~. Accredited EMS programs ~~were to will~~ utilize the appropriate ~~National EMS Education~~
20 ~~Standards~~ document as the basis for their education programs. Accreditation agencies ~~were to will~~ use the
21 ~~National EMS Education Standards~~ to evaluate the appropriateness of program curricula.

22
23 The EMS community and most EMS education programs ~~had have~~ a long history of reliance on the NSC.
24 The shift from a standardized curriculum to a system of ~~National EMS Education Standards was to must~~
25 occur ~~in tandem~~ with the growth and maturation of the other system components. ~~We cannot decrease our~~
26 ~~dependence on the NSC was to be decreased~~ before strengthening other components of the system,
27 especially accreditation and national certification. We ~~were to have moved are moving~~ from a system in
28 which consistency was ensured through standard content to one which seeks consistent high-quality
29 educational outcomes.

30 31 **Where We Are in 2015**

32
33 ~~The Education Standards were written sufficiently broadly to allow flexibility for instructional styles of~~
34 ~~individual EMS educators. This flexibility has the added benefit of permitting rapid change to curricula~~
35 ~~in response to evolving science without having to change the standard itself. Many changes will come~~
36 ~~from practice guideline updates issued by major medical organizations in addition to the available~~
37 ~~evidence-based guidelines (EBG).~~

38 39 **Minimal Updates based on Current Evidence**

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41 ~~The Education Standards may need to be revised on a periodic basis to remain up to date with current~~
42 ~~medical practice and science. As the Scope of Practice changes and evolves, the Education Standards~~
43 ~~may need to be adjusted as well. EMS educators will lead the revision process with input from the rest~~
44 ~~of the EMS community and other healthcare organizations.~~

45
46 ~~EMS personnel may occasionally be expected to function in roles not currently or sufficiently addressed~~
47 ~~in existing Scope(s) of Practice or Education Standards such as Traffic Incident Management (TIM),~~
48 ~~human trafficking, specific local needs, and response to natural and manmade disasters. These may~~
49 ~~include responses to mass casualty events such as Chemical, Biological, Radiological, Nuclear and~~
50 ~~Explosive (CBRNE) events; terror events; and, bioevents. EMS agencies and programs are instrumental~~
51 ~~in implementing educational objectives that ensure effective patient care while maintaining the highest~~
52 ~~level of patient and crew safety.~~

- 1 The following milestones are provided as illustrative steps that are likely to be taken but are not intended
- 2 to imply a specific sequence or order.
- 3

Milestones	Organizations/Resources Involved
Market the <i>EMS Education Agenda for the Future</i> to the EMS community and EMS organizations	EMS Education Task Force
Fund EMS educational improvement projects	Private, federal, state, and local governments
Revise the <i>Blueprint</i> and rename it the <i>National EMS Scope of Practice Model</i>	NHTSA, EMS medical community, EMS regulators, EMS educators, EMS providers
Develop <i>National EMS Education Standards</i>	NHTSA, EMS medical community, EMS regulators, EMS educators, EMS providers

NATIONAL EMS EDUCATION PROGRAM ACCREDITATION

In most countries government assumes the responsibility for ensuring the quality of post- secondary education. However, in the United States accreditation has become the accepted method of assuring students and the public of the quality of higher education. The primary purpose of accreditation is student and public protection. This is achieved by providing an independent, external, objective review of institutional and/or programmatic quality as comparison with accepted standards. Although accreditation benefits the institution, this is secondary to its role in consumer protection.

Accreditation is defined as a non-governmental, independent, collegial process of self and peer assessment. The purpose of accreditation is to provide a system of public accountability and continual improvement of academic quality. Education accreditation generally involves three major activities:

- The faculty, administration, and staff of the institution or program conduct a self-study using the accrediting association standards and guidelines.
- A team of peers selected by the accrediting agency reviews the evidence; visits the program; interviews the students, faculty, administration, and staff; and writes a report of its assessment.
- Guided by a set of expectations about quality and integrity, a commission reviews the evidence and recommendations, makes a judgment, and communicates the decision to the institution and the public.

Education accreditation provides a consistent mechanism of program evaluation and may eliminate the need for states to develop a separate program recognition process. Accreditation represents a method to assure the students and the community that an education program meets uniform, nationally accepted standards. Accreditation review includes assessment of structure, process and outcomes. Institutions are encouraged to develop creative and flexible methods to meet or exceed accreditation standards.

For institutions, accreditation stimulates continuous self-assessment and encourages self- improvement. It promotes sound educational change and provides institutions with validation to obtain the resources they need to improve. The essential values of accreditation are continuous self- improvement, professional excellence, peer review and collaboration, and civic responsibility.

Where We Were in 2000

While technically not accreditation, most states ~~had~~ ~~have~~ some process for approving EMS education programs. The requirements for these state approvals ~~varied~~ ~~vary~~ widely, from simply filing paperwork to extensive self-studies and site visits. State approval ~~was~~ ~~is~~ granted to institutions, courses, or individual instructors. In lieu of comprehensive programmatic evaluation, some states ~~have~~ developed and instituted instructor courses and credentialing as methods of ensuring program quality.

~~Currently,~~In 2000, accreditation ~~was~~ ~~is~~ voluntary and available only at the paramedic level. In most states, national accreditation ~~was~~ ~~is~~ optional. In 1999 there were approximately 100 accredited paramedic programs in the United States. No national accreditation ~~existed~~ ~~exists~~ at other EMS provider-level programs.

1 The only nationally recognized accreditation available for EMS education is through the Commission on
2 Accreditation of Allied Health Education Programs (CAAHEP) Joint Review Committee on Accreditation
3 of Educational Programs for the EMT-Paramedic (JRCEMT-P), renamed the Committee on Accreditation
4 of Emergency Medical Services Professions (CoAEMSP) on January 1, 2000. In 1998
5 CAAHEP accredited 18 recognized allied health occupations.

6
7 Most allied health professions limited licensure eligibility to individuals who **have** graduated from an
8 accredited education program. In this way, professions controlled educational quality. For EMS, this
9 linkage **has** occurred in only five states, and only at the paramedic level, as of 2000.

11 12 **Where We Wanted To Be in 2010**

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14 The concept of ~~National EMS Education~~ Program Accreditation **was to will** be universal and supported
15 by the EMS leadership organizations and stakeholders. A single, nationally recognized accreditation
16 agency **was to have will** been identified ~~created~~ and **was to have will** established standards and guidelines
17 for each level of EMS education. A single agency will provide a consistent structure, process, and
18 evaluation for all programs. The accreditation process **was to have will** recognized the special issues
19 involved in evaluating the entire range of EMS programs.

20
21 Universal acceptance of ~~National EMS Education~~ Program Accreditation **was to have will** resulted in
22 extensive self-assessment of EMS education programs and the implementation of continuous quality
23 improvement initiatives. Having clear standards and guidelines, programs will improve their faculty and
24 the overall quality of instruction. ~~They are Programs and instructors were to be~~ structure, process, and
25 outcome oriented. Programs and instructors **were to will** use the ~~National EMS~~ *Education Standards* and
26 commercially available or locally developed instructional support material to develop curricular ~~arum~~
27 materials.

28
29 Accreditation standards and guidelines **were to will** provide minimum program requirements for
30 sponsorship, resources, students, operational policies, program evaluation, and curriculum. Standards
31 **were have** also **to have** been developed for program faculty credentials and qualifications. Program
32 standards **were to will** be developed with broad community input, peer review, and professional review.
33 ~~National EMS Education~~ Program Accreditation **was to will** be universal and required for each level of
34 EMS provider identified in the ~~National EMS~~ *Scope of Practice Model*. In order to be eligible for
35 ~~National~~ EMS Certification and state licensure, a candidate **was to have must** graduated from an
36 accredited program.

37
38 Approval to conduct EMS education **was to have will** been extended by the states to all accredited
39 programs, in accordance with state laws.

40 41 **How We Wanted To Get There**

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43 A single, national accreditation agency **was to will** be identified and accepted by state regulatory offices.
44 This accrediting agency **was to will** have a board of directors with representation from a broad range of
45 EMS organizations. The accreditation agency **was to will** develop standards and guidelines for all levels
46 of EMS education with broad community input. All EMS accreditation **was to will** include self-study, site
47 visitation, and commission review, but the standards and guidelines **were to** vary according to level. The
48 accreditation agency **was to will** adopt the ~~National EMS~~ *Education Standards* as the basis for evaluating
49 the content of all EMS instruction and **was to will** develop a process for accreditation that is appropriate
50 for each level of EMS instruction as determined by the ~~National EMS~~ *Scope of Practice Model*.
51 Accreditation **was to will** be achieved by a process as close to other allied health occupations accreditation
52 as possible, given the resources and constraints imposed by the system.

1 A graduated phase-in plan ~~was to will~~ be developed for implementation of national accreditation. Each
 2 state ~~was to have should~~ identified a graduated time line for adoption. After the phase-in date, only
 3 graduates from accredited programs ~~were to will~~ be eligible for national certification to qualify for state
 4 licensure.

5
 6 The accreditation agency ~~should was to have~~ conducted regional accreditation workshops to increase the
 7 understanding of ~~National EMS Education~~ Program Accreditation and help programs achieve the
 8 accreditation standards and guidelines. Funding ~~continues to will~~ be critically needed to support short-term
 9 educational improvement projects which make accreditation more achievable.

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 11 **Where We Are in 2015**

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 13 According to the NASEMSO Implementation Survey published April 23, 2014, 90% of states effectively
 14 require National EMS Program Accreditation at the Paramedic level. National and regional accreditation
 15 workshops continue to be offered on a regular basis.

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 17 **Minimal Updates based on Current Evidence**

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 19 None

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 21 The following milestones are provided as illustrative steps that are likely to be taken but are not intended to
 22 imply a specific sequence or order.

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Milestones	Organizations/Resources Involved
Marketing of the EMS Education Agenda for the Future	EMS Education Task Force
Provide information about accreditation to EMS organizations	Accreditation experts
Fund EMS educational improvement projects	Private, federal, state, and local governments
Accept the National EMS Education Standards as the curriculum requirements for accreditation	National accreditation agency
Develop standards and guidelines for accreditation of all levels of EMS education, based on current curriculum standards and community input	National accreditation agency
Develop and conduct regional accreditation workshops to help programs get accredited	National accreditation agency
100% of the advanced programs accredited	State EMS offices, national accreditation agency, EMS education institutions
100% of the basic programs accredited	

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NATIONAL EMS CERTIFICATION

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Certification is the process of verifying competency at a predetermined level of proficiency. Licensure is the process of a state government agency granting official permission to practice within that given state. Although there are distinct differences, the terms “licensure” and “certification” are often used interchangeably. In actuality, licensure is the process of an agency making a declaration of competence to practice. The determination of eligibility for licensure is usually based on the completing of education requirements and the passing of an examination. Most licensure processes require some form of certification by either a state or national agency to ensure minimum competence.

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In most professions, development of examinations is the responsibility of an independent national board. State governments then use the certification as part of their licensing process. In the EMS professions, state government frequently assumes the responsibility of certifying eligible individuals as competent to practice based upon either locally developed, state-developed or contractor- developed examinations. In these circumstances, state government assumes the responsibilities of both certification and licensure.

Where We **Were in 2000**

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There ~~was is~~ great confusion and inconsistency in the definition and application of the terms certification, licensure, and registration throughout the states. Some form of testing ~~was is~~ one of the stages of granting licensure to EMS providers. Testing often ~~included includes~~ both practical and written components. The quality and difficulty levels of these examinations ~~varied vary~~ widely. Because of these variations, reciprocity and standardized minimum entry-level competencies ~~were have been~~ difficult to achieve.

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Many locally and state-authored examinations ~~did do~~ not adhere to the standards established by the American Psychological Association’s (APA) *Standards for Educational and Psychological Testing* utilized by other allied health care professions. In some instances locally authored examinations ~~were are~~ necessary because the state EMS provider levels ~~did do~~ not match the nationally recognized levels.

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~~Currently (2000)~~In 2000, about 40 state EMS regulatory agencies used some form of the National Registry of Emergency Medical Technicians (NREMT) examinations. This ~~may~~ included use of a single-level examination or the use of their examinations for all levels of EMS providers. The NREMT examinations ~~were are~~ based on a ~~current~~ practice analysis, ~~current in 2000~~, and the *Blueprint*. Their examinations ~~were are~~ authored by a multi- disciplinary group of experts with input from various EMS-related organizations. Each level of examination ~~was is~~ validated on a continuous basis.

Barriers to the universal use of national examinations included, but ~~were are~~ not limited to, cost of implementation and administration, political issues, the use of a mandated practical examination, lack of local support, and perceived failure rate.

Where We **Wanted To Be in 2010**

~~National~~ EMS Certification ~~was to will~~ be conducted by a single independent national agency under the leadership of a board of directors with multi-disciplinary representation. A single certification agency ~~was to will~~ provide a consistent evaluation of recognized EMS provider entry level competencies. ~~National~~ EMS Certification ~~was to will~~ be accepted by all state EMS offices as verification of entry level competency. ~~National~~ EMS Certification is one of the steps leading to licensure for levels of EMS providers specified in the

1 ~~National EMS Scope of Practice Model~~. In order to be eligible for ~~National EMS Certification~~,
2 candidates ~~were to have must~~ graduated from a nationally accredited EMS education program.

3
4 Certification examinations ~~were to be are~~ based on APA standards and a practice analysis. A nationally
5 recognized, validated, and reliable examination ~~was to be is~~ used by all state EMS agencies as a basis for
6 state licensure. ~~National EMS Certification was would~~ not ~~intended to~~ replace states' rights to license, but ~~to~~
7 ~~would~~ be used as one component of eligibility for licensure to practice within the state.

8 9 **How We Wanted To Get There**

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11 A single, national certifying organization ~~was to will~~ be identified and accepted by state regulatory offices.
12 This certification agency ~~was to will~~ have a board of directors with representation from a broad range of
13 EMS organizations. The national certification agency ~~was to will~~ regularly conduct a comprehensive
14 practice analysis for each level of nationally recognized EMS provider. This practice analysis ~~was to will~~
15 be used to develop and revise examinations for each level identified in the ~~National EMS Scope of~~
16 ~~Practice Model~~.

17
18 Examinations ~~were to will~~ be designed to verify entry level competence. Certifying examinations ~~were to~~
19 ~~will~~ adhere to the APA's *Standards for Educational and Psychological Testing*. Entry level competence
20 ~~was to will~~ be identified by the practice analysis. Certifying examinations ~~were to will~~ be based on practice
21 analysis and the ~~National EMS Scope of Practice Model~~, not on educational standards, curricula, or
22 textbooks.

23
24 A graduated phase-in plan ~~was to will~~ be developed for implementation of national certification. Each state
25 ~~was to have should~~ identified a graduated time line for adoption. After the phase-in date, all graduates ~~were~~
26 ~~to have must~~ successfully completed an accredited program of instruction and a national certification to
27 qualify for state licensure.

28
29 The national certifying organization should conduct regional workshops to increase the understanding of
30 ~~National EMS Certification~~ and emphasize the overall system advantages. This identified national
31 certifying organization ~~was should~~ also ~~to have helped~~ states overcome the barriers of implementation
32 whenever possible.

33 34 **Where We Are in 2015**

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36 Currently, 45 states use the NREMT examination process as a component of state licensure at one or more levels.
37 (NASEMSO Implementation Survey, April 23, 2014.)

38 In fall 2013, the percentage of States utilizing national exam for initial licensure are:

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- 41 • Emergency Medical Responder - 48%
 - 42 • Emergency Medical Technician - 80%
 - 43 • Advanced Emergency Medical Technician - 68%
 - 44 • Paramedic - 88%

45 **Minimal Updates based on Current Evidence**

46
47 None

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49 The following milestones are provided as illustrative steps that are likely to be taken, but are not intended
50 to imply a specific sequence or order.

Milestones	Organizations/Resources Involved
Marketing of the EMS Education Agenda for the Future	EMS Education Task Force
Fund EMS educational improvement projects	Industry, state, and federal governments
Conduct a practice analysis of all provider levels	National certification agency
Provide information about national certification to EMS organizations	National certification agency
Provide educational workshops in states that have not fully implemented national certification	National certification agency
100% of the states utilize national certification at all levels	State EMS offices

CONCLUSION AND NEXT STEPS

The *Education Agenda*, as minimally updated, continues to describe a future structure for our EMS education system and proposes a process by which this system will evolve. It is a vision that defines the EMS education system elements, describes their interrelationships, clarifies a decision-making process, establishes methods for input, and accommodates improved data and research. It defines a system which promotes national consistency and flexibility to allow for individual state variances, and facilitates rapid inclusion of innovative methods of patient care. The synergistic effects of the system are enormous; clearly, the whole is greater than the sum of its parts. The infrastructure laid out in this vision ensures a permanent, viable framework for national EMS education decision making and future planning. The shift toward this system will place new emphasis on educational quality and curriculum development, and on the performance of EMS instructors and educational facilities. However, instructor and program development are among the areas that receive the least attention in today's EMS educational system. To be successful in our implementation of the *Education Agenda*, we need to place a special focus on instructor and program development. This document was crafted with the expectation that quality EMS education will lead to superior EMS personnel, capable of providing the exceptional EMS care the public has come to expect and the EMS system was created to provide. ~~The next~~Ongoing steps in achieving this vision are to:

- ~~Ensure wide D~~distribution of this document to all ~~the~~ appropriate stakeholders;
- Educate the stakeholders on the value of this vision;
- Seek stakeholder acknowledgment that the vision is shared;
- ~~Begin development of~~Periodically revise the ~~National EMS~~ *Core Content, Scope of Practice, and Education Standards* as needed, in accordance with the approach described in this document; and,
- Establish ~~or recognize~~ a coordinating group consisting of representatives from major national EMS organizations charged with monitoring the implementation of the vision.

To guarantee the best EMS system in the future, we ~~must continue need~~ to be proactive ~~take action-~~now. With this document, the EMS community ~~took is taking~~ the first step, laying out a common goal that we can all work toward. This is a vision we can ~~continue to support approach~~ with confidence, knowing that it is the product of careful deliberation of our peers, technical experts, and leaders from across the range of EMS professions.

And while this vision reflects the best ideas from today's perspective, it is essential that as we follow this course we periodically assess our progress and ensure that our target continues to meet our collective needs. The basic concepts of system integration and instructional quality will stand the test of time, but we need flexibility in our means to these ends to allow for a changing environment.

Creating ~~and refining~~ the vision was a challenging task, but the real work ~~continues to lies~~ ahead. ~~F u l l~~ ~~implementation of~~ ~~Implementing~~ the vision will require commitment, determination, and persistence from EMS providers, educators, administrators, medical directors, and our public officials. But the rewards are compelling. We have the opportunity to achieve ~~ever higher new~~ levels of performance in our EMS systems and improve the quality of life of our patients and communities.

1
2 **GLOSSARY**
3
4

5 **Academic:** Based on formal education; scholarly; conventional.
6

7 **Academic institution:** A body or establishment instituted for an educational purpose and providing
8 college credit or awarding degrees.
9

10 **Accreditation:** The granting of approval by an official review board after specific requirements have
11 been met. The review board is non-governmental and the review is collegial and based on self
12 assessment, peer assessment, and judgment. The purpose of accreditation is public accountability.
13

14 **Advanced Emergency Medical Technician (AEMT):** A provider level within the *Scope of*
15 *Practice* for an individual who provides basic and limited advanced emergency medical care and
16 transportation for critical and emergent patients who access the emergency medical system. Such an
17 individual possesses the basic knowledge and skills necessary to provide such patient care and
18 transportation, consistent with the *Scope of Practice* and applicable State laws.
19

20 **Certification:** Certification is an external verification of the competencies that an individual has
21 achieved and typically involves an examination process. While certification exams can be set to any
22 level of proficiency, in health care, they are typically designed to verify that an individual has
23 achieved minimum competency to assure safe and effective patient care in accordance with the
24 appropriate scope of practice. ~~The issuing of certificate by a private agency based upon standards~~
25 ~~adopted by that agency that are based upon competency.~~
26

27 **Continuing education:** The continual process of life-long learning.
28

29 **Core content:** The central elements of a professional field of study. The core content does not specify
30 the course of study.
31

32 **Credentialing agency:** An organization which certifies an institution's or individual's authority or
33 claim of competence for a course of study or completion of objectives.
34

35 **Curriculum:** A particular course of study, often in a special field. For EMS education it has
36 traditionally included detailed lesson plans.
37

38 **Educational Affiliation:** An association with a learning institution (academic), the extent to which can
39 vary greatly from recognition to integration.
40

41 **Emergency Medical Responder (EMR):** A provider level within the *Scope of Practice* for an
42 individual who initiates immediate lifesaving care to critical patients who access the emergency medical
43 system. Such an individual possesses the basic knowledge and skills necessary to initiate basic
44 lifesaving interventions while awaiting additional EMS response and to assist higher level
45 personnel at the scene and during transport.
46

47 **Emergency Medical Technician (EMT):** A provider level within the *Scope of Practice*
48 for an individual who provides basic emergency medical care and transportation for critical and
49 emergent patients who access the emergency medical system. Such an individual possesses the basic
50 knowledge and skills necessary to provide such patient care and transportation, consistent with the
51 *Scope of Practice* and applicable State laws. ~~A member of the EMS team who provides out-of-hospital~~
52 ~~emergency care; includes certifications of EMT-Basic, EMT-Intermediate, and EMT-Paramedic which~~
53 ~~identify progressively advancing levels of care.~~
54

55 **EMS System:** Any specific arrangement of emergency medical personnel, equipment, and supplies
56 designed to function in a coordinated fashion. May be local, regional, state, or national.

1
2 **First Responder:** The title of the EMS provider within the National Standard Curriculum who was designated to
3 provide the initial level of care within an EMS system as defined by the *EMS Education and Practice Blueprint*. ~~The~~
4 ~~title of the EMS provider within the National Standard Curriculum for the initial level of care within an EMS system as defined by~~
5 ~~the *EMS Education and Practice Blueprint*.~~

6
7 **Licensure:** Represents permission granted to an individual by a sovereign political jurisdiction, such as a
8 State, to perform certain restricted activities. Scope of practice represents the legal limits of the licensed
9 individual's performance. States have a variety of mechanisms to define the boundaries of what an
10 individual is legally permitted to perform.

11 The act of granting an entity permission to do something that the entity could not legally do
12 without such permission. Licensing is generally viewed by legislative bodies as a regulatory effort to
13 protect the public from potential harm. In the health care delivery system, an individual who is licensed
14 tends to enjoy a certain amount of autonomy in delivering health care services. Conversely, the licensed
15 individual must satisfy ongoing requirements which ensure certain minimum levels of expertise. A license
16 is generally considered a privilege and not a right.

17
18 **National EMS Core Content:** The document which defines the domain of out of hospital care.

19
20 **National EMS Education Program Accreditation:** The accreditation process for institutions that
21 sponsor EMS educational programs.

22
23 **National EMS Education Standards:** The document which defines the terminal objectives for each
24 provider level.

25
26 **National EMS Scope of Practice Model:** The document which defines scope of practice for the various
27 levels of EMS provider.

28
29 **Outcome:** The short-, intermediate-, or long-term consequence or visible result of treatment,
30 particularly as it pertains to a patient's return to societal function.

31
32 **Paramedic:** A provider level within the *Scope of Practice* for an allied health professional
33 whose primary focus is to provide advanced emergency medical care for critical and emergent
34 patients who access the emergency medical system. Such an individual possesses the complex
35 knowledge and skills necessary to provide the highest level patient care and transportation,
36 consistent with the *Scope of Practice* and applicable State laws.

37
38 **Practice Analysis:** A study conducted to determine the frequency and criticality of the tasks performed
39 in practice.

40
41 **Registration:** A listing of individuals who have met the requirements of the registration service.

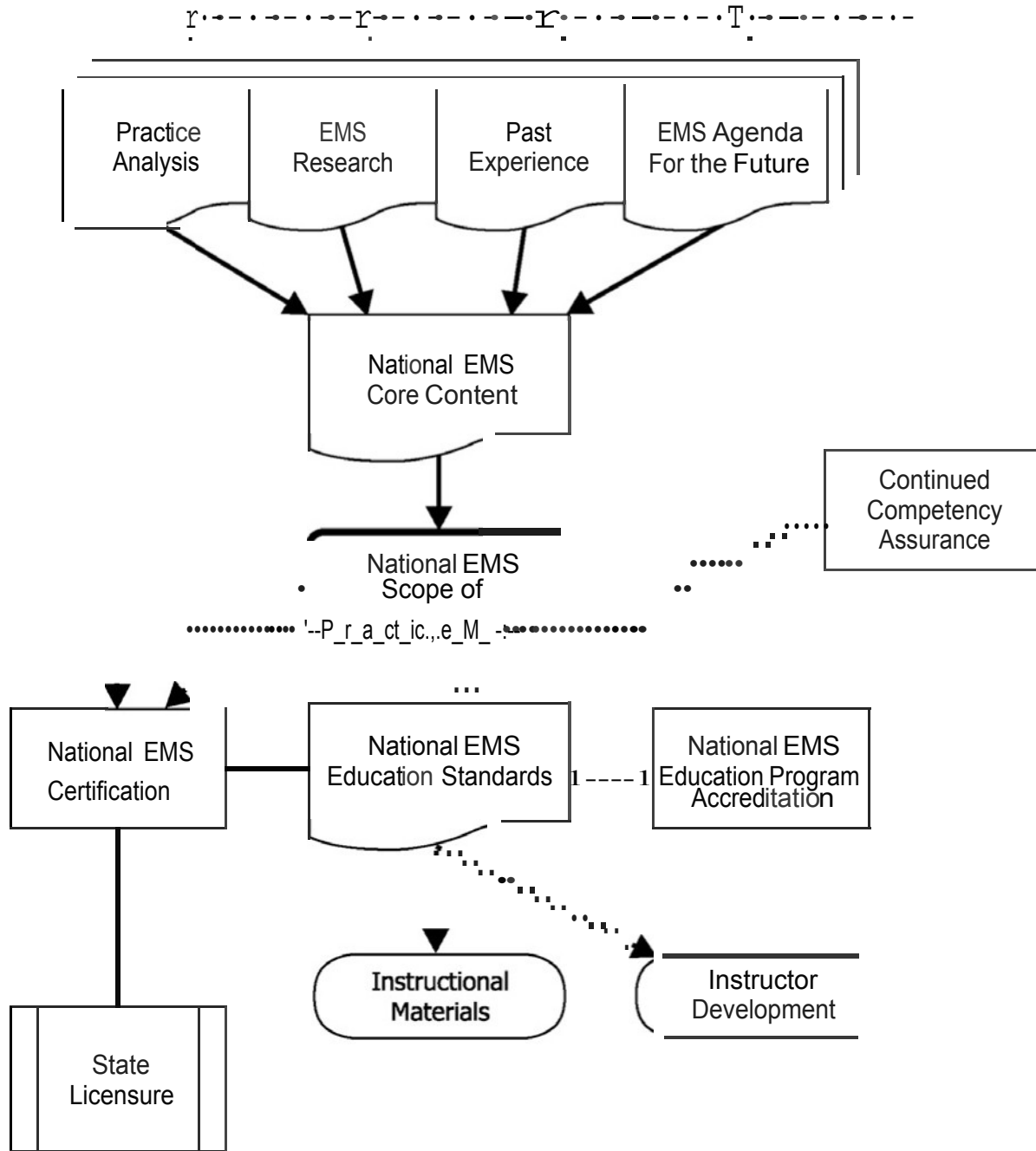
42
43 **Registration agency:** Agency traditionally responsible for the delivery of a product used to evaluate a
44 chosen area. States may voluntarily adopt this product as part of their licensing process. The registration
45 agency is also responsible for gathering and housing data to support the validity and reliability of their
46 product.

47
48 **Regulation:** Either a rule or a statute which prescribes the management, governance, or operating
49 parameters for a given group; tends to be a function of administrative agencies to which a legislative
50 body has delegated authority to promulgate rules/regulations to "regulate a given industry or
51 profession." Most regulations are intended to protect the public health, safety, and welfare.

52
53 **Scope of practice:** Defined parameters of various duties or services which may be provided by an
54 individual with specific credentials. Whether regulated by rule, statute, or court decision, it tends to
55 represent the limits of services an individual may perform.

- 1 **Testing agency:** Agency traditionally responsible for delivering a contracted examination. The
- 2 responsibility of interpreting the results and defending the validity of those judgments is placed on the
- 3 contractor.

APPENDIX A – EMS EDUCATION SYSTEM COMPONENTS



APPENDIX B 憫 EDUCATION PHILOSOPHY

Educational Outcomes

In addition to job-oriented skills, today's workers are expected to possess a capacity for problem solving, constructive skepticism, and the ability to manage ambiguity (Barth, 1990). Recent studies on narrowly focused and task-oriented curricula have concluded that "narrow emphasis on vocational skills is insufficient to achieve workforce success, and that vocational programs should emphasize the development of academic skills..."(Benz, 1997)

Post-secondary education is now emphasizing the role of basic education in the context of technical or vocational education and how it is used to develop the thinking process, foster understanding, and develop mastery in any occupation. Mastery of basic academic skills improves problem-solving capabilities and prepares the student for life-long learning.

Upon completion of any course of professional education, it is expected that a graduate possesses the skills, knowledge, and attitudes to enter the workforce. The safety of the public greatly depends on the competence of all health care providers. Unfortunately, competence is an extremely complicated and multi faceted issue. Although it is relatively easy to identify, quantify, and test cognitive and psychomotor competence, there is more to achieving competence than being technically adept.

In *Responsive Professional Education*, Stark, Lowther, and Hagerty (1986) proposed that professional preparation is a combination of developing both professional competence and professional attitudes. Professional competence includes the following six subcategories:

- *Conceptual competence* - Understanding the theoretical foundations of the profession.
- *Technical competence* - Ability to perform tasks required of the profession.
- *Interpersonal competence* - Ability to use written and oral communications effectively.
- *Contextual competence* - Understanding the societal context (environment) in which the profession is practiced.
- *Integrative competence* - Ability to meld theory and technical skills in actual practice.
- *Adaptive competence* - Ability to anticipate and accommodate changes (e.g., technological changes) important to the profession.

Contextual, integrative, and adaptive competence are not discrete topic areas and do not easily lend themselves to behavioral objectives. Programs and faculty members must constantly weave these issues into the conceptual and technical components of the course.

It is impossible for a standardized curriculum to identify specific objective and declarative material for contextual, integrative and adaptive competence, but their importance cannot be overstated. Individual instructors and programs must keep these competencies in mind as they are developing instructional strategies to build entry level competence. These competencies are often the result of leadership, mentoring, role modeling, a focus on high level cognition, motivation, and the other instructional skills of the faculty.

The development of professional attitudes is influenced and shaped by role modeling, mentoring, and leading by example. It is difficult to "teach" in a didactic sense. Generally, professional attitudes, such as the following, are best nurtured through leadership and mentoring.

- *Professional identity* - The degree to which a graduate internalizes the norms of a professional.
- *Ethical standards* - The degree to which a graduate internalizes the ethics of a profession.
- *Scholarly concern for improvement* - The degree to which a graduate recognizes the need to increase knowledge in the profession through research.
- *Motivation for continued learning* - The degree to which a graduate desires to continue to update knowledge and skills.
- *Career marketability* - The degree to which a graduate becomes marketable as a result of acquired training.

While it is the role of testing agencies to evaluate conceptual and technical competence, it is the role of the educational institution and the faculty to nurture, develop, encourage, mentor, and evaluate all components of professional competence.

Education and Training

The difference between education and training is not simply a matter of semantics. Generally speaking, education is a broad-based, theoretical endeavor designed to improve cognitive skills and decision making. Training, on the other hand, tends to be specific and practically oriented. This distinction is not to imply a hierarchy or value judgment. Education without training results in inert knowledge which lacks transfer to real life situations. Training with inadequate education results in narrow, task-oriented outcomes characterized by poor understanding, inadequate long-term retention, and little ability to change or adapt to situations which are dissimilar from the training environment. The most successful instruction strikes a balance between theory and practice and is a combination of both education and training.

Curriculum Consistency

Public expectations, political issues, legal considerations, and the need for interstate reciprocity of provider credentials all point to the need for some consistency in the content of education programs.

There are two approaches to curriculum consistency: one suggests that curriculum consistency should be achieved by standardized and mandated curricula; the other utilizes firm educational standards and a monitoring program to ensure that educational institutions, faculty, and regulatory agencies adhere to these standards.

EMS has attempted to ensure educational quality through the use of national standardized curricula. There is no doubt that these curricula have served an important function in the development of EMS and have played a major role in the growth and development of the profession. They have established the foundation of practice for EMS and were successful in defining a new area of practice.

On the surface, the rationale for the continued use of standardized curricula seems logical. Standardized curricula ensure that all classes are conducted in the same manner. Theoretically, this should produce similar outcomes. Unfortunately, standardized curricula do not account for variations in instructors, resources, and students. In EMS, outcome measurements still vary widely, despite the requirement that programs adhere to standardized curricula.

There is little evidence that standardized curricula improve classroom instruction or the quality of education (Airasian, 1988). In addition to having little evidence validating the effectiveness of standardized curricula, some researchers have suggested that there are detrimental effects (Brooks 1991). Some of these detrimental effect are:

- Lack of responsibilities of curriculum development at the local level (instructors, facilities, etc.).
- The impression that testing drives instruction.
- An emphasis on covering rather than teaching material.
- The impression that minimum competence is the desired outcome.
- Difficulty in being able to respond to identified local needs.
- Lack of ability to quickly respond to changes.

The second approach to curriculum consistency offers advantages for our evolving EMS education system. This model establishes standards and guidelines for process and product variables in EMS education. Typically, these standards and guidelines address areas such as sponsorship, resources, curriculum, evaluation, and program planning. Programs are required to adhere to standards and guidelines with an external review process to ensure compliance. This system offers a method of ensuring appropriate curriculum content while placing responsibility for instruction at the local level, enabling flexibility, encouraging creativity, and facilitating rapid change.

APPENDIX C 欄 DOCUMENT IDENTIFICATION, DESCRIPTION, AND RESPONSIBILITIES

Document	Description	Responsibility	Notes
EMS Agenda for the Future	Document that creates a vision for EMS	NHTSA and various EMS-related organizations	Document used to develop, revise, and direct national EMS issues
National EMS Core Content	Describes the entire domain of pre-hospital care	Medical community with assistance from regulators, educators, and providers	Drives the revision of the practice model, very general in nature and defines the pre-hospital care spectrum
National EMS Scope of Practice Model	Divides and defines the levels (name) and the performance of the levels of the various pre-hospital providers	Regulators with assistance from the medical community, educators, and providers	Requires enough detail to determine scope of practice
National EMS Education Standards	Objectives that define the terminal performance of the student (each level)	Educators assisted by regulators, medical community, and providers	Easily updated and guides development of program lesson plans
National EMS Education Program Accreditation	EMS education program approval based on universally accepted standards and guidelines	EMS accreditation agency	Inclusive of instructor and instructional material reviews
National EMS Certification	Standardized testing completed after graduation from an accredited EMS program that leads to state licensure	EMS certification agency	Development based on a practice analysis for the given level to include validity and reliability

APPENDIX D Ⅳ STRENGTHENING CONSUMER PROTECTION: PRIORITIES FOR HEALTH CARE WORKFORCE REGULATION

Excerpts from the *Summary of Recommendations, Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* - Task force on Health Care Workforce Regulation (1998)

REGULATORY BOARDS AND GOVERNANCE STRUCTURES

- Recommendation 1 Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement.
- Recommendation 2 States should require policy oversight and coordination for professional regulation at the state level. This could be accomplished by the creation of an oversight board composed of a majority of public members or it could become the expanded responsibility of an existing agency with oversight authority. This policy coordinating body should be responsible for general oversight of the state's health licensing boards and for assuring the integration of professional regulation with other state consumer regulatory efforts (e.g. health facility and health plan regulation).
- Recommendation 3 Individual professional boards in the states must be accountable to the public by significantly increasing the representation of public, non-professional members. Public representation should be at least one-third of each professional board.
- Recommendation 4 States should require professional boards to provide practice-relevant information about their licensees to the public in a clear and comprehensible manner. Legislators should also work to change laws that prohibit the disclosure of malpractice settlements and other relevant practice concerns to the public.
- Recommendation 5 States should provide the resources necessary to adequately staff and equip all health professions boards to meet their responsibilities expeditiously, efficiently and effectively.
- Recommendation 6 Congress should enact legislation that facilitates professional mobility and practice across state boundaries.

SCOPES OF PRACTICE

- Recommendation 7 The national policy advisory body recommended above develop standards, including model legislative language, for uniform scopes of practice authority for health professions. These standards and models would be based on a wide range of evidence regarding the competence of the professions to provide safe and effective health care.
- Recommendation 8 States should enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body.

Recommendation 9 Until national models for scopes of practice can be developed and adopted, states should explore and develop mechanisms for existing professions to evolve their existing scopes of practice and for new professions (or previously unregulated professions) to emerge. In developing such mechanism, states should be proactive and systematic about collecting data on health care practice. These mechanism should include:

- Alternative dispute resolution processes to resolve scope of practice disputes between two or more professions;
- Procedures for demonstration projects to be safely conducted and data collected on the effectiveness, quality of care, and costs associated with a profession expanding its existing scope of practice; and
- Comprehensive legislative “sunrise” and “sunset” processes that ensure consumer protection while addressing the challenges of expanding existing professions’ practice authority, and regulating currently unregulated healing disciplines.

CONTINUING COMPETENCE

Recommendation 10 States should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers.

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APPENDIX E 例 DOCUMENT SAMPLES

This section includes a format sample for the components referenced in the *EMS Education Agenda for the Future: A Systems Approach* document. The examples provided are samples for conceptual understanding only. The samples were created by the authors of the *EMS Education Agenda for the Future* using the 1990's revision of the respective *EMS National Standard Curricula* NSC. They are designed to be illustrative, not restrictive. The authors for each of the actual component documents will alter the format as needs and methodology evolve.

To illustrate how one component of the *EMS Education Agenda for the Future* affects and relates to all the other components, the examples that are provided begin with the *National EMS Core Content*. The authors of the *EMS Education Agenda for the Future* have demonstrated a sample of what the adult pulmonary section of the *National EMS Core Content* document could look like. We have expanded the adult pulmonary section to include a level of detail that would be included throughout the document. Each section of the final document would follow the example of that model section. The adult pulmonary sections of the *National EMS Scope of Practice Model* and the *National EMS Education Standards* are also presented as samples to help illustrate what their formats and level of detail could look like.

National EMS Core Content

What We Anticipated in 2000:

Core Content Categories

PREPARATORY AND OPERATIONS

- 1 EMS Systems
- 2 The Roles and Responsibilities of the EMS Providers
- 3 The Well-Being of the EMS Provider
- 4 Illness and Injury Prevention
- 5 Medical / Legal Issues
- 6 Ethics
- 7 General Principles of Pathophysiology
- 8 Pharmacology
- 9 Venous Access and Medication Administration
- 10 Therapeutic Communications
- 11 Life Span Development
- 12 Ambulance Operations
- 13 Medical Incident Command
- 14 Rescue Awareness and Operations
- 15 Hazardous Materials Incidents
- 16 Crime Scene Awareness
- 17 Communications
- 18 Documentation
- 19 Airway Management and Ventilation
- 20 History Taking
- 21 Techniques of Physical Examination
- 22 Patient Assessment
- 23 **Mass Casualty Care [suggested addition in 2014]**

TRAUMA

- 23 Trauma Systems
- 24 Mechanism of Injury
- 25 Hemorrhage and Shock
- 26 Soft Tissue Trauma
- 27 Burns
- 28 Head and Facial Trauma
- 29 Spinal Trauma
- 30 Thoracic Trauma
- 31 Abdominal Trauma
- 32 Musculoskeletal Trauma
- 33 **Special Populations (pediatric and geriatric) [suggested addition in 2014]**

MEDICAL

- 33 Pulmonary
 - 33.1 Acute/ adult respiratory distress syndrome
 - 33.2 Obstructive airway diseases
 - 33.2.1 Asthma
 - 33.2.2 Chronic bronchitis
 - 33.2.3 Emphysema
 - 33.3 Pneumonia
 - 33.4 Pulmonary edema
 - 33.5 Pulmonary thromboembolism
 - 33.6 Neoplasms of the lung
 - 33.7 Upper respiratory infection

	33.8	Spontaneous pneumothorax
	33.9	Hyperventilation syndrome
34		Cardiology
35		Neurology
36		Endocrinology
37		Allergies and Anaphylaxis
38		Gastroenterology
39		Renal/Urology
40		Toxicology
41		Hematology
42		Environmental Conditions
43		Infectious and Communicable Diseases
44		Behavioral and Psychiatric Disorders
45		Gynecology
46		Obstetrics
47		Neonatology
48		Pediatrics
49		Geriatrics
50		Abuse and Assault
51		Patients with Special Challenges
52		Acute Interventions for the Chronic Care Patient

Where We are in 2015: <http://ems.gov/education/EMSCoreContent.pdf>

National EMS Scope of Practice Model

What We Anticipated in 2000:

Level A

Respiratory arrest
Respiratory distress
Mouth to mask ventilation

Level B

Respiratory failure
Exacerbated Chronic Obstructive Pulmonary
Diseases
Hyperventilation syndrome
Supplemental Oxygen Therapy
Bag-Valve-Ventilation
ATV
Assisted Inhaled Beta Agonists

Level C

Asthma
Chronic bronchitis
Emphysema
Administered Inhaled Beta Agonists
Endotracheal intubation

Level D

Acute/ adult respiratory distress syndrome
Pneumonia
Pulmonary edema
Pulmonary thromboembolism
Neoplasms of the lung
Upper respiratory infection
Spontaneous pneumothorax
Comprehensive emergency pharmacological management
CPAP
BiPAP

Where We are in 2015: <http://ems.gov/education/EMSScope.pdf>

National EMS Education Standards (SAMPLE)

What We Anticipated in 2000:

Level A

The entry level A provider must be able to recognize and provide immediate, life saving interventions for a patient with a respiratory emergency.

The entry level First Responder must be able to:

Identify and recognize and provide immediate, life saving interventions for the following respiratory emergencies:

- a. Respiratory arrest
- b. Respiratory distress

Recognize and value the assessment and treatment of patients with respiratory diseases.

Demonstrate safe, effective, and proper

- a. Mouth to mask ventilation

Level B

The entry level B provider must be able to recognize and implement the treatment plan for the patient with a respiratory emergency.

The entry level B provider must be able to perform all the objectives of the A provider, plus:

Identify and describe the function of the structures located in the upper and lower airway.

Discuss the physiology of ventilation and respiration.

Discuss abnormal assessment findings associated with respiratory emergencies.

Review the use of equipment used during the physical examination of patients with respiratory emergencies.

Identify and implement a treatment plan for respiratory emergencies:

- a. Respiratory failure
- b. Exacerbated Chronic Obstructive Pulmonary Diseases
- c. Hyperventilation syndrome

Recognize and value the assessment and treatment of patients with respiratory diseases.

Demonstrate safe, effective, and proper

- a. Mouth to mask ventilation
- b. Supplemental Oxygen Therapy
- c. Bag-Valve-Ventilation
- d. ATV
- e. Assisted inhaled beta agonists

Safely assist patients in taking their own prescribed medication during a respiratory emergency.

Level C

The entry level C provider must be able to apply assessment findings and implement the treatment plan for the patient with respiratory emergencies.

The entry level C provider must be able to perform all of the objectives of a B provider, plus:

Identify and describe the function of the structures located in the upper and lower airway.

Discuss the physiology of ventilation and respiration.

Identify common pathological events that affect the pulmonary system.

Discuss abnormal assessment findings associated with respiratory emergencies.

Compare various airway and ventilation techniques used in the management of respiratory emergencies.

Review the use of equipment used during the physical examination of patients with complaints associated with respiratory diseases and conditions.

Identify the pathophysiology, assessment findings, and management for the following respiratory diseases and conditions:

- a. Adult respiratory distress syndrome
- b. Bronchial asthma
- c. Chronic bronchitis
- d. Emphysema
- e. Hyperventilation syndrome

Recognize and value the assessment and treatment of patients with respiratory diseases.

Indicate appreciation for the critical nature of accurate field impressions of patients with respiratory diseases and conditions.

Demonstrate safe, effective, and proper

- a. Mouth to mask ventilation
- b. Supplemental Oxygen Therapy
- c. Bag-Valve-Ventilation
- d. ATV
- e. Endotracheal intubation

Safely administer pharmacological agents used in the management of respiratory emergencies.

Level D

The entry level D provider must be able to integrate pathophysiological principles and assessment findings to formulate a field impression and implement the treatment plan for the patient with respiratory problems.

The entry level D provider must be able to perform all of the objectives of a level C provider, plus:

Identify and describe the function of the structures located in the upper and lower airway.

Discuss the physiology of ventilation and respiration.

Identify common pathological events that affect the pulmonary system.

Discuss abnormal assessment findings associated with pulmonary diseases and conditions.

Compare various airway and ventilation techniques used in the management of pulmonary diseases.

Review the use of equipment used during the physical examination of patients with complaints associated with respiratory diseases and conditions.

Identify the epidemiology, anatomy, physiology, pathophysiology, assessment findings, and management for the following respiratory diseases and conditions:

- a. Adult respiratory distress syndrome
- b. Bronchial asthma
- c. Chronic bronchitis
- d. Emphysema
- e. Pneumonia
- f. Pulmonary edema
- g. Pulmonary thromboembolism
- h. Neoplasms of the lung
- i. Upper respiratory infections

- j. Spontaneous pneumothorax
- k. Hyperventilation syndrome

Recognize and value the assessment and treatment of patients with respiratory diseases.

Indicate appreciation for the critical nature of accurate field impressions of patients with respiratory diseases and conditions.

Demonstrate safe, effective, and proper:

- a. Mouth to mask ventilation
- b. Supplemental Oxygen Therapy
- c. Bag-Valve-Ventilation
- d. ATV
- e. Endotracheal intubation
- f. CPAP
- g. BiPAP

Safely administer pharmacological agents used in the management of respiratory patients.

Where We are in 2015: <http://ems.gov/pdf/811077a.pdf>

APPENDIX F: MEMBERS OF THE 1998 EMS EDUCATION TASK FORCE

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“Parking Lot” Issues

During the public comment period and the NEMSAC Education Agenda Revision Committee’s deliberations, there were several important issues raised that were deemed to be significant changes to the *Education Agenda* and not minor revisions. NEMSAC recommends NHTSA provide this list to those tasked with doing a more substantial revision of the *Education Agenda* in the future.

- Minimum of National EMS Certification required for every State
- Move toward Paramedics holding a minimum of an Associate of Applied Science degree.
- Designate a Federal lead agency for EMS.
- During the public comment, there was significant support for utilizing the single national accreditation and certification agencies. There were also some concerns expressed regarding this approach due to monopoly and cost control issues. This may be a subject for future discussion.
- Explore how simulation-based training and distributive and distance learning (e. g. telehealth) may improve EMS education delivery.
- Encourage growth and development of individuals with terminal degrees to enhance the overall development of the EMS profession and ascertain the appropriateness and feasibility of a future doctorate in EMS.
- Explore opportunities to transition other healthcare providers (nurses, military medics, physician assistants, respiratory therapists, etc.) into the EMS profession.
- Consider changing “National EMS Certification” to “National EMS Personnel Certification”