Original NEMSAC Bucket List of Ideas and Activities to Discuss

Bucket 1 of 8*

**Administration - Structure/System**

- Organization and integration of air medical services
- There’s no universal method for EMS systems inventory & workload nationwide
- Absence of governmental responsibility and accountability to assure provision of EMS
- Standardized response time expectation/performance measures
- Standardized definitions and performance measures, but not standardized response times – will vary widely by type of service, location, etc.
- System fragmentation
- Enhanced coordination between state Highway Safety and EMS Offices
- Integration of regionalized, accountable, and coordinated systems of Pediatric Emergency Care
- Assessing differences in EMS systems by configuration; clinical capability
- NTSB-style oversight of EMS agency crashes
- Access to trauma systems
- Integrating with other community systems
- Emergency department overcrowding, patient diversion
- System redesign in rural/frontier & austere settings
- There needs to be a lead Federal EMS agency
- Mechanisms for immediate interstate legal recognition
- No pervasive performance improvement systems transparent and accessible to all
- Interface: integration with other health, public health partners.
- Joint planning with public health and health care agencies, prophylaxis for first responders including families, integration of GIS, patient tracking.
- Information sharing across EMS agencies across different cities/states/countries, the possibility of sending people to other services for a week or two, this might be nice as a nationally sponsored program.
- Some sort of online application that would house lessons learned, protocols, templates, after action reports, etc, kind of like LLIS, with some sort of security built in.
- EMS role in regional systems of care -trauma, STEMI, stroke, pediatrics, obstetrics
- Consider different types of providers for rural EMS such as expanded scope of practice for existing health professionals, such as community health aid.
- Establish model systems for both rural EMS and urban EMS with guiding principles, core issues and operational plans

*Italics* indicate areas in which NEMSAC committees have made previous progress. There may have been further progress made by other national groups or federal agencies.
Bucket 2 of 8

Finance - Funding/Billing
- Medicare reimbursement – pay for performance & what it means for EMS
- Base reimbursement on performance standards not transport and readiness for
defined geographical areas
- **EMS reimbursement in general – currently emphasis is on taking patient to
hospital since that is the only way to be reimbursed. Should focus more on cost of
readiness, prevention programs, treat/release, and perhaps even transport to
other health care settings besides ER (health clinic, etc.)**
- Equitable access to federal grants for EMS agencies, including private/non-profit
EMS providers that do emergency work
- Funding for medical oversight
- Adequate funding for personnel, infrastructure, equipment from non-
reimbursement sources
- Adequate financial support for research
- Money for EMS infrastructure
- Medicaid funding
- Funding source to rebuild EMS infrastructure
- Defined and adequate benefit assurance (third-party payments)
- Recognize and support readiness costs
- Provide reimbursement for non-transports

Bucket 3 of 8

Human Resources - Education, Certification, Workforce and Safety
- Interstate credentialing and licensing, including how to handle volunteers at
major incidents
- Ensure equitable access to accredited education programs – geographic, financial,
etc.
- **Standardized certification, licensure and credentialing of personnel, agencies and
systems**
- Adopt the “5-part model” (EMS Education Agenda for the Future) and it’s
influence /effect on initial education, national certification, and improving
reciprocity
- Staffing resource capabilities both for day-to-day and surge
- Recruitment and retention of increasingly professional staff
- Leadership development
- Pay and benefits for EMS personnel
- Safety of EMS personnel
- **Safety of personnel – include vehicle design, lighting, conspicuity, lifting/transfer
devices, protection from exposure, highway safety, driver training**
- Recruiting young people, getting parental support
- Keeping training and performance requirements within reach of the volunteers;
- Mechanisms for immediate interstate legal recognition
• EMT/Paramedic injuries/wellness and mental health readiness (pre and post)
• Recruitment, but I would recommend focusing not only on young people, but also people who would make the job a career and stay for the long haul.
• Some sort of online application that would house lessons learned, protocols, templates, after action reports, etc, kind of like LLIS, with some sort of security built in.
• Minimum Standard EVOC programs

Bucket 4 of 8

Operations and Equipment
• Communications systems, interoperability
• There needs to be some method to evaluate the efficacy and performance of new devices
• Lack of operational systems integration

Bucket 5 of 8

Public Education and Information
• Public education and information
• Promoting recognition among the public of the importance of EMS
• Public expectations exceed actual EMS/911 capacity
• Leveling public recognition and appreciation for EMS compared to other public safety services

Bucket 6 of 8

Research, Technology, and Data
• Better standardization and collection of EMS related data points
• EMS participation in Health Information Enterprise
• Institutional Review Boards & EMS research
• Data; belief and ownership and compliance (NEMSIS)
• A nationwide EMS crash database with common data points to collect/study the problem
• Mapping/GIS/Data Analysis
• CAD to CAD interfaces for quickly sharing information
• Emergency medical Dispatch/Wireless 9-1-1/Voice over Internet Protocol (VOIP)
• Vehicle crash telematics – AACN
• Some sort of online application that would house lessons learned, protocols, templates, after action reports, etc, kind of like LLIS, with some sort of security built in.
• Support electronic patient care records to allow for 100% case review
**Bucket 7 of 8**

**Medical Oversight and Quality**
- Clarification/standardization of when it is appropriate to call for helicopter transport
- Application of advanced QI
- Standardized response time expectation/performance measures
- EMS QI programs should have some sort of peer review protections that hospitals have – this will encourage more “no fault” reporting of incidents and near misses to identify/fix system issues
- Standardized definitions and performance measures, but not standardized response times – will vary widely by type of service, location, etc.
- Medical oversight
- Physicians should have more oversight of standards – for example, a physician should be able to determine what type of response and response time goals are medically appropriate for a system.
- Sub-specialization for EMS MDs
- *Patient safety and medical errors*
- No pervasive performance improvement systems transparent and accessible to all
- Place an emphasis on interventions which “make a difference” rather than concentrating on response time standards
- Create EMS protocols which are evidence-based and seamless between First response and Transport

**Bucket 8 of 8**

**Disaster Preparedness**
- Emergency Preparedness – national recommendations for training, planning, resources, stockpiling, as well as alt standards of care, might be helpful, not to mention a national EMS EP grant.
- Regionalize protocols, equipment and medical oversight, etc. for disaster response