NEMSAC Priority Issues - First Round Voting  
July, 2008

Administration - Structure/System
- Establish model systems for both rural EMS and urban EMS with guiding principles, core issues and operational plans - 15
- System fragmentation - 14
- Interface: integration with other health, public health partners - 14
- Absence of governmental responsibility and accountability to assure provision of EMS - 13
- EMS role in regional systems of care - trauma, STEMI, stroke, peds, ob - 12
- Joint planning with public health and health care agencies, prophylaxis for first responders including families, integration of GIS, patient tracking. - 12
- There needs to be a lead Federal EMS agency – 11
- Consider different types of providers for rural EMS such as expanded scope of practice for existing health professionals, such as community health aid. - 10
- Integrating with other community systems - 10
- Standardized definitions and performance measures, but not standardized response times – will vary widely by type of service, location, etc. - 10
- System redesign in rural/frontier austere settings - 9
- Mechanisms for immediate interstate legal recognition – 7
- 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. – 7
- Organization and integration of air medical services - 7
- Emergency department overcrowding, patient diversion – 7
- There’s no universal method for EMS systems inventory & workload nationwide - 6
- NTSB-style oversight of EMS agency crashes - 7
- No pervasive performance improvement systems transparent and accessible to all - 6
- Access to trauma systems - 5
- Standardized response time expectation/performance measures - 4
- Integration of regionalized, accountable, and coordinated systems of Pediatric Emergency Care - 4
- Assessing differences in EMS systems by configuration; clinical capability – 4
- 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. - 4
- Enhanced coordination between state Highway Safety and EMS Offices - 1
Finance - Funding/Billing

- 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.) - 22
- Equitable access to federal grants for EMS agencies, including private/non-profit EMS providers that do emergency work - 15
- Adequate funding for personnel, infrastructure, equipment from non-reimbursement sources – 14
- Adequate financial support for research - 10
- Recognize and support readiness costs - 8
- Funding source to rebuild EMS infrastructure - 6
- Medicare reimbursement – pay for performance & what it means for EMS - 5
- Base reimbursement on performance standards not transport and readiness for defined geographical areas - 5
- Funding for medical oversight - 5
- Provide reimbursement for non-transports - 4
- Defined and adequate benefit assurance (third-party payments) - 2
- Medicaid funding – 2
- Money for EMS infrastructure - 2
Human Resources- Education/Cert/ Workforce (Safety)

- Leadership development - 18
- Standardized certification, licensure and credentialing of personnel, agencies and systems – 17
- Safety of personnel – include vehicle design, lighting, conspicuity, lifting/transfer devices, protection from exposure, highway safety, driver training – 16
- Ensure equitable access to accredited education programs – geographic, financial, etc. - 13
- Interstate credentialing and licensing, including how to handle volunteers at major incidents - 11
- Recruitment and retention of increasingly professional staff – 11
- Adopt the “5-part model” (EMS Education Agenda for the Future) and it’s influence /effect on initial education, national certification, and improving reciprocity – 11
- Safety of EMS personnel – 8 – (merge with #3 above)
- Keeping training and performance requirements within reach of the volunteers; - 8
- 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. - 8
- Pay and benefits for EMS personnel - 7
- EMT/Paramedic injuries/wellness and mental health readiness (pre and post) - 6
- Minimum Standard EVOC programs - 6
- Staffing resource capabilities both for day-to-day and surge - 4
- Mechanisms for immediate interstate legal recognition - 4
- 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. - 2
- Recruiting young people, getting parental support - 0
Operations and Equipment

• Communications systems, interoperability - 12
• Lack of operational systems integration - 8
• There needs to be some method to evaluate the efficacy and performance of new devices - 5
Public Education & Information

- Leveling public recognition and appreciation for EMS compared to other public safety services - 12
- Public education and information - 7
- Promoting recognition among the public of the importance of EMS - 4
- Public expectations exceed actual EMS/911 capacity - 2
Research/ Technology/ Data

- Better standardization and collection of EMS related data points - 19
- Data; belief and ownership and compliance (NEMSIS) - 15
- EMS participation in Health Information Enterprise - 10
- Mapping/GIS/Data Analysis – 9
- Support electronic patient care records to allow for 100% case review - 9
- A nationwide EMS crash database with common data points to collect/study the problem - 9
- Institutional Review Boards & EMS research - 8
- Emergency medical Dispatch/Wireless 9-1-1/Voice over Internet Protocol (VOIP) - 7
- 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. - 7
- CAD to CAD interfaces for quickly sharing information - 4
- Vehicle crash telematics – AACN - 3
Medical Oversight/ Quality

- Standardized definitions and performance measures, but not standardized response times – will vary widely by type of service, location, etc. – **15**
- Place an emphasis on interventions which “make a difference” rather than concentrating on response time standards - **14**
- Patient safety and medical errors – **13**
- Create EMS protocols which are evidence-based and seamless between First response and Transport - **12**
- 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 - **12**
- Application of advanced QI - **8**
- Medical oversight - **6**
- Clarification/standardization of when it is appropriate to call for helicopter transport - **5**
- 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. - **5**
- Standardized response time expectation/performance measures - **4**
- Subspecialization for EMS MDs - **3**
- No pervasive performance improvement systems transparent and accessible to all - **3**
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. - 17
- Regionalize protocols, equipment and medical oversight, etc. for disaster response - 8
Buckets in Priority Order

Administration – Structure/System - 14
Human Resources – Education/Certification/Workforce - 12
Finance – Funding/Billing - 8
Public Education & Information – 8
Research/Technology/Data - 6
Medical Oversight/Quality - 5
Disaster Preparedness - 3
Operations & Equipment - 1